COMPREHENSIVE MANAGED CARE PROGRAM FEEDBACK

OKLAHOMA HEALTH CARE AUTHORITY
4345 N. LINCOLN BLVD. | OKHCA.ORG |

SoonerCare Comprehensive Managed Care Program
Feedback

Managed Care Enrollees: Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

1. How and when should OHCA transition ABD and other initially excluded individuals to managed care?
    a. Do not transition until the MCOs can prove they have contracted with already established community organizations, such as Health Access Networks to allow for whole person care. Complex care management needs to have the ability to provide care outside the confinements of the practice or MCO. Utilizing a community-based model, such as the Health Access Networks would provide a neutral third party involved in the complex care.

2. Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
    a. Whether it is decided to separate or combine these populations, the key will be ensuring the MCOs have the correct partners engaged who have the expertise in caring for these populations. Additionally, MCOs must ensure all staff involved in serving these populations have, at minimum, training in the effects of social determinates, trauma informed approach, adverse childhood events, and cultural consciousness.

3. How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?
    a. Require evidence of "philosophy of engagement" which at a minimum needs to include inclusiveness, person-centered care, people first language, motivational interviewing, trauma informed approach, and whole person care
    b. If Sooner Care 2.0 is implemented, allow SoonerCare members opportunities for premiums, co-pays, and other costs to be waived.

Benefits Provided through MCOs: Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits.

1. What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
    a. Issues accessing health care is often about more than a desire or an inability. Health literacy is an important part. MCO's must be required to learn about their members, the communities where they live, and develop programs that help educate from early ages the importance of health care. Social determinants of health must be considered throughout the lifespan. Barriers to care need to be addressed in a person-centered approach.
    b. These programs cannot be punitive for example, not "firing" members from clinics for missing appointments, especially when a behavioral health issue is present. MCO's need to be required to utilize programs already developed and established within communities, to help with access such as Healthy Steps, Heath Access Networks, etc.

    c. Building community networks. So many programs in Oklahoma have already made tremendous strides in creating comprehensive whole person care programs. MCO need to be required and/or incentivized to contract with these groups. MCO network providers need to receive a financial incentive to work with the various complex care groups or other established health programs. Similar to the model for Health Neighborhoods, that was being developed for the PCMH Redesign

2. What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, share assessments and planning, and data sharing?
    a. Use of an HIE, but with expanded coverage of community services and care management information. Care plans from all programs need to be shared through the HIE.

3. How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor migration strategies?
    a. Use of a common referral tracking tool agnostic of any one EMR or other system. A referral tool such as the one utilized by the Sooner Health Access Networks, that is web based, easy to use, can interface with other systems and is agnostic of any EMR.
    b. Having the ability to track referrals to social groups is vital to measure the success of the MCO in addressing social issues.
    c. Referrals must be tracked at a detailed level not just that it was sent and a report received.
    d. MCOs should make available a referral-tracking tool, such as the one utilized by the Sooner Health Access Network, especially for smaller practices within their Network that do not have robust tracking within their electronic health record systems.
    e. MCOs need to incentivize specialty providers to participate in referral tracking systems and ensuring referral loop closure.
    f. MCOs should explore paying for the use of e-consults when a specialty appointment could be avoided and/or there are not enough specialty providers available.
    g. MCO's should be required to contract with groups well trained in addressing social issues or at a minimum the MCO must provide evidence of staff completing trainings focused on motivational interviewing, cultural consciousness, trauma informed approach, and addressing social needs.

4. How can MCO's improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication-assisted treatment for opioid use disorder or, assertive community treatment?
    a. MCO's should be required to contract with groups such as the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) who has already developed a proven model for influencing changes at the primary care level.
    b. True community based behavioral health: Behavioral health services cannot be restricted to an office setting, likewise, it cannot be expected that individuals with significant behavioral health issues must go to an office to receive services. MCOs need to offer reimbursable telehealth services, which need to include phone-to-phone services for those members who do not have smart devices or internet access.
    c. When in-patient behavioral health care is required, individuals should not have to travel across the State to obtain care.

5. What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
    a. Person Centered Care Management Services, that includes but not limited to home visits, attending PCP and specialty care appointments, in-patient visits and transition care services, addressing social needs, etc.
    b. In home therapy
    c. In home primary care services
    d. Caregiver support and services
    e. Standardized training for care managers. The OU Sooner Health Access Network has work over that last seven years to develop a training that is based on national standards as outlined by the National Center for Quality Assurance (NCQA), motivational interviewing, trauma informed approach, risk with dignity, person-centered planning cultural consciousness, behavioral health, and chronic disease management. A standardized comprehensive training requirement is critical to ensuring all SoonerCare Members have access to qualified complex care management services.
    f. Member and caregiver education
    g. Transportation, including but not limited to same day appointments
    h. Assistance with access to healthy foods

6. How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?
    a. Transportation services should be carved out of the MCO's requirements.
    b. Allow Transportation service provides such as Sooner Ride to be more innovative and adjust to members needs
    c. Need to be able to book rides for same day appointments
    d. Ability to travel with children – always; Example: if a parent needs to transportation to take a child to an appointment, but has three children they care for, they need to be able to bring all the children, not just the one who has an appointment.
    e. Ride share options are extremely necessary, need easy way to educate members and pay for services. Ride share drivers need to have minimum training expectation.

Quality and Accountability: MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

1. What mechanisms should the state use to incentivize MCOs to improve member outcomes?
    a. It is vital that the MCO's be required to contract with established community programs such as HealthySteps and the Health Access Networks. Both these programs have proven beneficial to helping Oklahomans improve health outcomes. More importantly, these initiatives directly tie to the desire for Oklahoma to become a top 10 state.
    b. MCO's should be required and/or incentivized to contract with established community programs, such as HealthySteps, Health Access Networks, and CHIO's.
    c. Practices within the MCO Network should receive financial incentives for participating with programs offered within the MCO such as Health Access Networks and HealthySteps.
    d. Performance pay plans – adjusting for risk groups
        i. Incentives for not just providers but other groups involved as well
        ii. Pay for Performance must be set at a level that exceeds the standard. We should not be paying for standard care, but exceptional care

2. What are the most important indicators of MCO performance? Why?
    a. Person Reported Outcomes
    b. Standardized Outcome measures – such as lower A1C
    c. Provider satisfaction

3. What measures of health outcomes should be tracked?
    a. Member satisfaction
    b. Disparities in health and social outcomes at the state, county, zip code and provider levels

Care Management and Coordination: MCOs have experience managing members' health, including for populations with complex or multiple needs.

1. How can utilization management tools work best for members and providers?
    a. A robust HIE that all providers are required to connect to must be in place for transparent utilization management.
2. How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
    a. Ensure all practices have access to necessary data and information.
    b. MCOs must make available to all practices support services that can help educate the practice on utilization management and carry part of the administrative burden. This would be an excellent opportunity for programs that are already in place to continue to be involved with contracts with the MCO. Health Access Networks already have these services available to their network practices.
3. What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
    a. Home-based behavioral health needs must be expanded and incentivized.
4. How can MCOs improve the management and coordination for members with chronic or complex health conditions?
    a. MCOs must be required to contract with established groups within the state and build upon what has already been implemented. These programs need to be evidence-based, person centered, and comprehensive. The Health Access Networks have been in existence for a decade and have proven results. A 2018 Pacific Health Policy Group evaluation was completed examining utilization and expenses twelve months prior and twelve months after care management intervention through the Health Access Networks. Some of the reported findings include:
        i. $3.2 million dollar savings in the 12 months after care management services were initiated
        ii. 50.7% reduction in Inpatient Hospital Utilization for members with Asthma
        iii. 37.2% reduction in ER Utilization for members who were considered "High ER Utilizers"
        iv. 20.8% reduction in Inpatient Hospital utilization for Aged, Blind and Disabled members with Diabetes.
    b. Providers within the MCO networks need to be required and incentivized to interact with the complex care organizations. These organizations need to be agnostic of a specific practice so they can truly coordinate care across disciplines.

5. What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and other whose needs present unique considerations?
    a. Adequate and comprehensive training needs to be required for all staff working in these areas.
    b. The same as with all people with complex needs, services need to include, but not limited to, transportation, after hours and weekend access to urgent and non-urgent care, timely access to mental health services and facilities, comprehensive and intensive in-person and telephonic care management services with long-term follow up as needed (not time limited), available and affordable medications and DME, and community based collaborations. The complex care managers for these populations need to be agnostic of one specific practice.
    c. Take advantage of programs already established within these communities by requiring MCOs to contract with Health Access Networks, Health Steps, and other programs.

Member Services: Medicaid MOCs must follow federal rules for providing responsive and meaningful member assistance

1. What metrics should be used to measure MCO performance with regards to member services?
    a. Patient Reported Outcomes need to be one of the primary elements of measurement. There is significant work being completed by NQF, NCQA, the National Center for Complex and Social needs and others that need to be evaluated and included.
    b. Evidence based and standardized metrics across all MCOs that measure health and social outcomes, processes, provider and a person's experience with providers and the MCO.
2. How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
    a. Recruiting bi-lingual staff should be incentivized but at minimum evidence of relationship with language line or other service
    b. Staff must be trained in cultural consciousness

3. How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
    a. Unfortunately, many members within the Medicaid population may not have access to this technology and/or have the literacy level to utilize the technology. The MCO's may need to consider providing the technology in some cases.
4. How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
    a. Provide any needed devices members would need to fully access those services
    b. Utilize community based outreach programs.
5. How can MCOs communicate with members and receive regular input and feedback on program improvements?
    a. MCOs need to be required to have a member advisory board and at least one member who sits on any governing boards for the MCOs.
6. What tools and resources would help members search for providers? What information should be provided?
    a. Access to available providers needs to be multi-faceted. A robust online search tool is required, but also a telephonic option that allows a member to gain easy access to a live person to talk about their options. At minimum, this information needs to be available

in Spanish and when using the telephonic services MCO staff need access to other interpreter services.

Provider Payments and Services: Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

1. What metrics should be used to measure MCO performance with regards to provider services?
    a. In order to be a top 10 state providers must be incentivized to meet beyond the standard, but it is recognized that the provider may not have the ability or knowledge to accomplish this goal. By incentivizing providers that collaborate with programs such as Heathy Steps or a Health Access Network, they would have the support to reach the next level.
2. Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?
    a. Yes, a minimum level of reimbursement should be set.
    b. OHCA needs a process in place that allows for auditing of provider contracts to ensure equitable reimbursement for all providers. There must be safe guards in place for the small practices to be reimbursed adequately compared to larger organizations with more negotiation power.
3. What is appropriate for timely payment of claims?
    a. Weekly
4. What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?
    a. Offer ongoing education and training opportunities in the area of quality.
    b. Health Access Networks have been providing quality improvement support and education for a decade. MCOs need to actively engage these groups to continue this process. When a MCO affiliate practice chooses to participate in this offering an incentive payment is made available to both the practice, the Health Access Network and the MCO when agreed upon outcomes are improved.
    c. HealthySteps has a proven track record of promoting the health, well-being and school readiness of babies and toddlers, with any emphasis on families living in low-income communities.
5. How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?
    a. Training – Standardized Care Management Training requirements
    b. Practice Facilitation – require MCOs to contract with programs experienced in providing this service.
    c. Provide the appropriate services and resources for a practice to be successful. This must include building off current success and proven programs throughout the state. These programs include HealthySteps, Health Access Networks, the Oklahoma Primary Healthcare Improvement Cooperative, etc.

Network Adequacy: Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care:

1. How should MCOs work with providers to ensure timely access to care standards are met?
    a. NCQA outlines standards for access to care. MCOs should require practices to meet these minimum standards.
    b. MCOs need to ensure practices do not have punitive practices in place in order to appear they are meeting standards. Including but not limited to ability to “fire”

members for missing appointments or “non-compliance”, especially when behavioral health, social determinates and historical trauma issues are present.

Request #80720200002

SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

Prepared for

Oklahoma Health Care Authority (OHCA)

Submitted by:

August 17, 2020

Managed Care Enrollees

How and when should OHCA transition ABD and other initially excluded individuals to managed care?

Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Benefits Provided through MCOs

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

Access to reliable, safe transportation is vital to improving health outcomes, prevention, and member satisfaction in any Medicaid program. Members cannot receive adequate medical service, or follow-through on prescribed treatment-regimens, if they have no way to get to and from their medical appointments. Therefore, it is important the Oklahoma Medicaid program includes non-emergency medical transportation (NEMT).

MTM is working collaboratively through the Medical Transportation Access Coalition (MTAC) to educate the Centers for Medicare and Medicaid Services (CMS) and legislative officials on the value of NEMT. For instance, MTM helped fund an independent study through the MTAC to examine the role transportation plays in improving member health outcomes.

The study, conducted by Faegre Baker Daniels Consulting, Wakely, and Dr. Patricia Salber, evaluated the use of NEMT in correlation to three conditions and corresponding treatments: Dialysis for Kidney Disease, Wound Care for Diabetic Wounds, and Treatment for Substance Use Disorder (SUD). The study supports the hypothesis that missed medical appointments lessens patient adherence with clinical guidelines, which leads to complications and expensive medical services. Findings of the study include:

- 58% of nearly 1,000 of respondents reported they would not be able to make any medical appointments without NEMT
- 10% of respondents reported they would die or probably die when asked would happen if they did not have the transportation services they currently receive
- Respondents receiving dialysis who use NEMT reported attending an average of 12 dialysis treatments a month in accordance with clinical guidelines, but could attend an average of only 4.1 treatments a month without it
- Respondents with diabetes-related wounds who use NEMT reported attending an average of 5.5 wound care treatments a month, but could attend an average of only 1.3 treatments a month without it

Members who used NEMT services for scheduled medical appointments based on prescribed treatment regimens – such as the clinically recommended number of dialysis sessions or wound treatments – enjoyed better health and incurred significantly lower long-term costs than those who did not maintain regular appointments. The study estimated the value of NEMT (return on investment) per 30,000 members per month to be more than $40 million per month.

As demonstrated by this study, and held as a core belief at MTM, reliable access to transportation is vital to improving health outcomes, prevention, and member satisfaction, as well as containing cost for the Medicaid program.

MTM also recommends providing non-medical transportation (NMT) to support social determinants of health (SDOH) such supporting individuals who live in food desserts with transportation to grocery stores; reducing isolationism by transporting individuals to activities like church or social groups; promoting stable employment with reliable transportation to work; etc. It has been proven that access to quality healthcare, economic stability, neighborhood and physical environment, education, food quality and stability, and community and social contact highly impact people's health and MTM is equipped to address these aspects by providing quality, reliable transportation for those who most need it.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

MCOs can improve access to transportation for SoonerCare members by selecting an experienced, qualified NEMT broker to manage the transportation benefit. Using a NEMT broker helps control cost, improve service quality, and streamline NEMT delivery for facilities and members alike. The broker model is highly recommended by CMS to promote service uniformity and quality.

Specifically, a qualified NEMT broker will deliver the following benefits for OHCA, MCOs, and members:

- **Cost Savings:** A single NEMT broker is positioned to reduce, assign patients to the appropriate mode of transportation, and deploy other industry-best practices that contain costs.
- **Neutral Third Party:** NEMT brokers serve as a neutral third party, using proven methods to determine the most appropriate, lowest cost mode of transportation and negotiate rates with transportation providers.
- **Streamlined Access:** By contracting with a NEMT broker, MCOs and OHCA can access accurate program data reported in aggregate, using consistent metrics, as well as a holistic view of the program without having to consolidate data from multiple sources.
- **Reduced Administrative Burden:** A NEMT broker relieves administrative duties from both MCOs and OHCA associated with managing a network of several transportation providers—including credentialing drivers and vehicles, reconciling claims, resolving complaints, and more.

A NEMT broker can improve transportation access for SoonerCare members by leveraging transportation resources throughout the state, such as:

- Locally and regionally coordinated transportation programs, such as transportation provided by Area Agencies on Aging, Senior Citizen Centers, and Job and Family Services
- Facilities and/or centers who provide transportation to their patients/members
- Public transportation systems
- Commercial transportation providers
- Independent contractors
- Volunteers
- Transportation Network Companies (TNCs) like Uber and Lyft
- Self-transport with Gas Mileage Reimbursement (GMR)

It is important for MCOs to select a contractor who has the necessary experience and capacity to not only handle the required transportation, but also the administrative functions of the contract. Many providers, although able to provide transportation, are ill-equipped to handle call intake; monitor fraud, waste, and abuse; process claims for other providers; provide state-mandated reporting; and ensure ongoing compliance with all CMS requirements.

With our broker expertise, MTM routinely handles each of these aspects of transportation programs. For the NEMT programs under our management, we enforce the most appropriate mode of transport with thorough eligibility verification and need assessments while leveraging cost-effective modes such as public transit, gas mileage reimbursement, and community provider resources.

To ensure MCOs contract with the responsible and capable NEMT broker, MTM recommends OHCA/MCOs require the NEMT broker to possess the following minimum qualifications:

- At least 10 years of experience administering NEMT programs similar in size and scope
- At least 10 years of experience implementing similar programs, including those in nearby states, smoothly and successfully, with established transition processes
- At least 10 years of experience managing large state and/or federally funded NEMT populations of 500,000 or more Medicaid members
- An in-market team to support operations

Incorporating TNCs

When used to augment comprehensive existing networks like MTM's, TNCs like Lyft and Uber are a natural evolution of the NEMT industry to fill gaps and potentially lower overall costs. MTM collaborates with Lyft and Uber to enhance on-demand service—particularly in response to short notice and on-demand trips, such as those for hospital discharges and will calls. This not only promotes adherence to timeliness and performance standards, it provides cost savings, as Lyft/Uber's standard rates are typically below the market rates we would pay transportation providers for short notice and on-demand trips. This allows MTM to provide members with high quality, on-demand service while achieving cost savings in your NEMT benefit. Yet, we understand TNCs are not appropriate for every member/situation; we let clients handpick specific instances where MTM should use Lyft or Uber to transport members to make sure we use these services as appropriate and approved by the MCOs/agency. Using TNCs only where appropriate gives members a modern transportation experience, while allowing clients to avoid TNC shortcomings for high-risk or vulnerable members.

For instance, TNCs experience high driver turnover, wait time, surge pricing, and turnback trips. They also cannot provide the level of member assistance or long distance trips MTM's traditional providers can. Further, our dispatch team closely watches TNC trips to make sure they occur as scheduled, and we perform targeted audits for any mileage discrepancies.

To date, MTM has implemented on-demand transportation resources, such as Lyft and Uber in several states. We are working with Lyft and Uber to enhance the member experience and ease challenges, like venue mapping which allows us to set a specific pick-up location at medical facilities to avoid issues and delays connecting members to their drivers.

MTM has also worked to remove as much risk as possible from using TNCs. For example, our Logistics staff perform audits on Lyft and Uber driver files to confirm accuracy of licensure and insurance information. However, it is important for OHCA to understand that no company can hold TNC drivers or vehicles to the same standards for NEMT as subcontracted transportation providers. MTM is proud to maintain a stringent credentialing process to verify the qualifications of every transportation provider, driver, and vehicle within our network. TNCs and companies using a purely independent contractor model cannot match the level of credentialing and service MTM provides though our network of contracted transportation providers.

Quality and Accountability

What mechanisms should the state use to incentivize MCOs to improve member outcomes?

What are the most important indicators of MCO performance? Why?

What measures of health outcomes should be tracked?

Care Management and Coordination

How can utilization management tools work best for members and providers?

How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

Members with chronic or complex health conditions often require numerous medical appointments and treatments, and it is imperative these members attend their appointments as scheduled by their physicians. One way MCOs can better manage and coordinate care for these members is to make sure members have access to reliable, safe transportation so they can obtain the treatment and care they need.

What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

As previously noted, MCOs can greatly reduce barriers to care by ensuring members have access to reliable, safe transportation. By contracting with a qualified NEMT broker, MCOs can better accommodate the health needs of all populations, including those who present unique considerations like children in foster care, AI/AN members, and SMI members. Getting members to and from their medical appointments helps them overcome a common barrier to receiving preventative care and following-through on prescribed treatment regimens.

Member Services

What metrics should be used to measure MCO performance with regards to member services?

How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

How can MCOs communicate with members and receive regular input and feedback on program improvements?

What tools and resources would help members search for providers? What information should be provided?

Provider Payments and Services

What metrics should be used to measure MCO performance with regards to provider services?

Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

What is appropriate for timely payment of claims?

What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

How can MCOs best communicate to providers about updates and changes to plan policies?

How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

Network Adequacy

How should MCOs work with providers to ensure timely access to care standards are met?

What are reasonable time and distance standards in Oklahoma by provider type?

How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

Grievances and Appeals

How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

How can the state and MCOs use appeals data to improve utilization management and access?

Administrative Requirements

How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data do require?

What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

LogistiCare®

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

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LogistiCare

Executive Summary

LogistiCare Solutions, LLC is the nation's largest provider of non-emergency medical transportation (NEMT) programs for state governments and managed care organizations (MCOs), handling more than 300 customized NEMT programs across all 50 states and the District of Columbia. In 2019, we coordinated 63 million trips for 24 million eligible Medicaid and Medicare recipients nationwide. Our depth of experience managing NEMT programs means we have repeatedly faced — and overcome — a wide array of Medicaid transportation management challenges. As the largest and most experienced Broker of NEMT services, we currently operate NEMT models under subcontracts with managed care organizations as well as through direct Medicaid agency contracts, as is currently the case in Oklahoma. Given our vast experience operating in both environments, we are uniquely positioned to offer best practice recommendations as it relates to NEMT program management.

Figure 1: LogistiCare partners with managed care organizations and Medicaid agencies across the nation to provide safe and reliable non-emergency medical transportation services. Through our robust network of 5,000 transportation providers and 22,000 vehicles, we maintain a complaint-free rating of 99%.

LogistiCare is writing to provide input to the state of Oklahoma on the question under "Benefits Provided through MCOs" as it pertains to the non-emergency medical transportation benefit. As the state of Oklahoma's trusted Broker since 2003, LogistiCare is intimately familiar with the NEMT landscape and has a firm grasp on what does and does not work for the state's Medicaid population. This submission will provide a summary of the current program, as it exists today, as well as insight into the complications that have arisen in other markets associated with transitioning the NEMT benefit under managed care.

State Broker History

By way of background, Oklahoma has used a statewide Broker since 1999 to operate its NEMT program. Under this brokerage model arrangement, NEMT services are provided under a capitated payment structure that provides multi-year budget predictability for the Oklahoma Health Care Authority (OHCA). All Medicaid transportation needs, statewide, are managed by one entity which provides full transparency into program statistics, utilization, trends, and costs.

As the statewide Broker since 2003, we have partnered to provide a vehicle through which the State can offer flexible NEMT benefits that directly respond to the needs of its Medicaid members, maximized cost

savings through bold initiatives, and collaborated with the OHCA and healthcare facilities to help the most vulnerable populations achieve better outcomes.

The following highlights provide a snapshot of the services we delivered in collaboration with the OHCA across all counties in 2019:

Figure 2: As the state of Oklahoma's chosen partner since 2003, LogistiCare uniquely understands the intricacies of the OHCA's NEMT program and the needs of its Medicaid members. Each year, our staff coordinates more than 931,760 trips and responds to over 574,800 calls in partnership with OHCA.

Our ability to collaborate, evolve, and adapt to the state's changing needs and requirements has played a key role in the NEMT program's success.

Moving Forward

The state has the important responsibility of selecting the best program model to ensure eligible Medicaid members, statewide, have ease of access to medical care and services that improve their quality of life. LogistiCare appreciates the state's consideration of our perspective and recommendations and would welcome the opportunity to speak in greater detail regarding our concerns.

Benefits Provided through MCOs

How can MCOs improve access to transportation for SoonerCare members?

While we currently contract with a large number of managed care organizations (MCOs) nationally, our expertise would discourage an MCO carve-in model over the current statewide brokerage model in Oklahoma. When responsibility for management and oversight of the NEMT benefit resides within managed care, these entities inevitably choose to subcontract responsibility for program management to qualified Brokers. While a health plan serving as a conduit to the Broker would "place responsibility" with them, this arrangement results in various forms of administrative duplication which minimizes the opportunity for states to maximize efficiencies and cost savings.

Under this arrangement, the transportation Brokers would ultimately be subcontractors of the MCOs; thus removing any and all oversight of the Program from the Department. In these instances, a second layer of cost is created, as is another layer of reporting and communication; placing the agency further away from the direct oversight of the Program it currently maintains.

Assuming the state will implement a multi-plan solution for managed care, this approach could result in four different transportation Brokers operating in the state (one Broker per plan and one Broker for the remaining fee for service population). When multiple MCOs with overlapping geographies are responsible for managing the NEMT benefit, it fragments the transportation provider coverage of the Broker; substantially reducing their negotiating power which has proven to result in increased costs associated with securing transportation services. This arrangement ultimately shifts leverage to the transportation providers versus the Brokers as they are in a position to negotiate higher rates by forcing the Brokers to compete against one another in order to establish a sufficient network. Over time, the network becomes fragmented and coordination at the local level, especially in rural areas, comes at a significantly higher cost. Historically, this arrangement also tends to limit the network's ability to multi-load as little to no coordination is permitted to take place between transportation Brokers.

As it relates to Oklahoma specifically, there are roughly 50 transportation companies statewide that offer NEMT services. Unlike urban markets where transportation resources are abundant and the network can be supplemented as needed, this is not the case in Oklahoma. If the state were to introduce multiple Brokers to the equation, all charged with competing over these limited transportation resources, the outcome will inevitably result in decreased service quality, higher complaints, and increased costs.

Additionally, having multiple transportation Brokers in the same geographic area working for multiple MCOs often leads to further confusion for the transportation network and adds additional administrative burdens to the Program as local transportation companies are required to understand and work within the different systems of the various transportation Brokers. This fragmentation also makes it confusing for both members and healthcare facilities as they attempt to navigate who is responsible for providing NEMT services and may no longer have access to the transportation providers who they have grown accustomed to being transported. This scenario creates multiple contact points for medical providers and transportation companies, and simply adds more, and potentially conflicting, layers of bureaucracy onto the existing transportation infrastructure and network which will ultimately lead to confusion and added inefficiencies for all stakeholders.

Furthermore, the elimination of state procurement rules associated with the MCO subcontracting process would allow transportation Broker selection by the MCOs to be based on cost alone which could

undermine the Program's integrity. More often than not, the increased profit MCOs retain through management of the NEMT Program results in overaggressive negotiations amongst Brokers, leading to a less than adequate network and/or a network of poorly credentialed transportation providers.

For these reasons we implore the state of Oklahoma and the Oklahoma Health Care Authority to retain control of the NEMT benefit under state procurement to ensure continuity of care for its' most vulnerable population.

Continued Benefits of Maintaining Current Statewide Brokerage Model

- Improved call center performance
- Budget predictability and sustainability for the State
- Increased credentialing and oversight of transportation providers
- Higher service quality for OHCA, including full transparency into program details and statistics
- Better collection and reporting of program data
- Reliable transportation services throughout the entire state
- Reduction of fraud, waste, and abuse because transportation Broker assumes financial risk of the program
- Reduction of administrative expenses because there is only one contract for OHCA to administer

Consequences of Carving-In Medical Transportation Program into Managed Care

- Oversight of the program removed from State, resulting in decreased transparency and control
- Additional layers of administrative expense
- Indirect communication with clients
- Various forms of administrative duplication which minimizes cost savings and program efficiencies
- Confusion for Members, healthcare stakeholders, and transportation providers
- Additional layers of reporting and communication
- Slower response time to OHCA
- Conflicting layers of bureaucracy onto the transportation network
- Fragmented transportation provider coverage
- Decreased service quality
- Increased program costs

States with Similar Circumstances

We recognize the dilemma the state of Oklahoma faces in determining the best course of program management. When confronted with similar circumstances, the following sixteen states strategically chose to implement managed care for their Medicaid populations while leaving the NEMT benefit carved out under direct state control:

- Colorado
- Delaware
- Georgia
- Kentucky

- Maryland
- Nevada
- New Jersey
- New York
- Pennsylvania
- Rhode Island
- South Carolina
- Texas
- Utah
- Washington
- West Virginia
- Wisconsin

We encourage you to contact these states to discuss the advantages and disadvantages of maintaining a state-led program.

In Summary

We appreciate the opportunity to share our knowledge and experience as you explore service models and initiatives that offer continued improvements to the Medicaid program. We are honored to submit our feedback, excited about the future direction of the NEMT program, and stand ready to continue to help Oklahoma achieve its program goals.

Benefits of Ride-Sharing Services

Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

On-demand ride sharing resources, like Uber and Lyft, can fill gaps and lower transportation expenses when used to augment an established network. Oklahoma's current transportation program permits the use of ride sharing services for urgent and recovery situations and short notice trips, such as hospital discharges and will calls. To ensure the holistic needs of SoonerCare members continue to be met, we consider it a best practice for the state to permit responsible use of ride-sharing resources. This not only promotes adherence to timeliness and performance standards, but it also enhances member satisfaction and provides cost savings.

While we strongly encourage the use of ride sharing services as a backup resource, it is important to note that not all trips can be appropriately accommodated using this option. We typically limit ride sharing services to ambulatory members in metropolitan and urban areas to free commercial providers to cover advance notice and long distance trips. We do not consider ride sharing services as an appropriate mode for members requiring a higher level of care and/or service. Through our member interview process, and in conjunction with the treating facility, we are able to determine the safest and most appropriate mode of transportation for each member based on their unique circumstances.

Benefits of Continuing Ride-Sharing Services

- Shortened member wait times
- Recovery of late trips and last-minute no-shows
- Enhanced member satisfaction
- Minimized no-shows
- Reduced costs for on-demand and short notice trips
- Improved timeliness for hospital discharges and will calls

In Conclusion

We understand Oklahoma's challenges and opportunities, and are best positioned to continue to provide the most innovative and comprehensive partnership available in our industry today — one that is well suited to support the nuances of the state's NEMT program. We appreciate the opportunity to submit our feedback for your consideration and invite you to contact us with any questions. Additionally, we welcome the opportunity to discuss your program goals and our capabilities at your convenience.

August 13, 2020

Kevin Corbett, CEO
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Via Email: Procurement@okhca.org

RE: SoonerCare Comprehensive Managed Care Program

Dear Mr. Corbett:

On behalf of the Choctaw Nation of Oklahoma, I submit these comments in response to the June 18, 2020 announcement by Governor Kevin Stitt and the Oklahoma Health Care Authority (OHCA) that the state would seek proposals from qualified managed care organizations (MCOs) for the Medicaid program (SoonerCare). An initial comment period on program design has been announced with a deadline of August 17, 2020.

We appreciate OHCA agreement to develop a joint OHCA/Tribal working group on managed care, where we have had dialogue on most of the issues and recommendations within this letter. Two virtual meetings have been held thus far, and we look forward to continuing these important conversations. We have significant concerns about transitioning SoonerCare to an outside managed care model, as such models present unique administrative and care coordination challenges for American Indian/Alaska Native (AI/AN) patients that we serve. Our detailed comments and recommendations are as follows:

AI/AN should not be auto-enrolled in managed care. While it may seem reasonable to assume that including all AI/AN in managed care would increase the managed care pool, and therefore allow the OHCA to negotiate a lower per-person rate with the Managed Care Organizations (MCOs), we question whether that will bear out in the case of AI/ANs. Having an opt-out provision could result in a larger pool which may lead to lower initial per capita costs for purposes of negotiating an amount with the MCOs; however, it most likely will not translate to lower overall costs for the state. This is because the state will have to pay the MCO based on the assumption that all AI/ANs stay in. Unless the state gets the anticipated opt-out percentages calculated correctly, the state could be subject to significant additional costs that could dwarf any savings they might get by having a larger actuarial pool by implementing it as opt-out. As a result, an opt-out policy for AI/AN has the state bearing the risk. An opt-in policy for AI/AN, on the other hand, puts the risk on the MCOs. If more AI/ANs opt-in than expected, the additional costs will be borne by the MCOs, not the state. As a result, opt-out for AI/AN creates significant financial risk for the state, while opt-in does not. In addition, we assume that the capitated per-person rate paid to MCOs for AI/AN will not be matched at 100% FMAP, which should be considered as well.

Medicaid Managed Care has been very difficult to implement in Indian country. MCOs often have little to no familiarity with the Indian health system and routinely disregard the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal laws. Indian Health Care Providers (IHCPs), which include Indian Health Service, Tribal and Urban health systems, cannot sign most MCO provider agreements because they contain provisions that are not designed for Tribal governments or federal Indian health care providers, and MCOs routinely use a one-size fits all approach to contracting, often refusing to negotiate the terms of those agreements with IHCPs. For example, MCO contracts impose state licensing and credentialing requirements on IHCP providers they are not required to meet or are inconsistent with federal law. These contracts often include legal forums such as state courts, dispute resolution and similar provisions that require waivers of sovereign immunity by a Tribe. MCO contracts contain payment mechanisms inconsistent with IHCP reimbursement rights under the Medicaid statute, and prior authorization requirements that are inconsistent with IHCP rights under the Medicaid statute and Managed Care Rule. MCO contracts also require insurance coverage requirements inconsistent with IHCP coverage under the Federal Tort Claims Act.

There is significant precedence in other states of MCOs routinely refusing to pay IHCPs even though they are required to by federal law when IHCPs are out of network, requiring significant additional work on the part of the States, CMS and the Tribes to work out reimbursement mechanisms and compliance. While we have a good working relationship with the OHCA, we have observed that despite good relationships, other states continue to have challenges in maintaining compliance. Even after education on the IHCP protections, MCOs must make system changes to ensure that claims from IHCPs are not routinely rejected, which has not happened at all in some states. MCOs impose additional and/or redundant care coordination and prior authorization requirements that may improve patient care for non-Indian Medicaid enrollees, but which are fundamentally inconsistent with how IHCPs already effectively manage their patients' care.

IHCPs already provide high quality care coordination. Unlike the non-Indian provider system, the Indian health care system in Oklahoma is already an integrated care delivery system. Our clinics and hospitals have developed sophisticated patient engagement, care integration, referral and outreach delivery systems. Examples include chronic disease management; population health; integrated behavioral health; integrated pharmacy; ancillary services such as lab and radiology; specialty care; optometry and dental; and environmental facilities services such as safe water and sanitation, and injury prevention. In addition to health services, most Tribes have other governmental services such as housing, family support services, transportation, nutrition, higher education and training. IHCPs (no matter their size) already coordinate care between our direct health care system, purchased and referred care provider networks, other IHS/Tribal systems, Veterans Health Administration and others. Layering a MCO's different and redundant care coordination system on top of the IHCP system is wasteful, confusing for patients and will be fraught with administrative complexity.

Congress enacted special Indian Medicaid managed care protections to help address these issues.

- SSA 1932(a)(2)(C) provides that no Indians may be mandatorily enrolled in managed care through a State Plan Amendment
- American Recovery and Reinvestment Act of 2009, P.L. 111-5 (Feb. 17, 2009), provides Managed Care protections in Section 5006 – a summary:
    - 5006(a), Exemption from Medicaid cost sharing (including co-pays) for Indian patients served by IHS, tribal and urban Indian organization (I/T/U) providers, including referrals under Contract Health Services (CHS) program
    - 5006(b), Exemption of certain Indian-owned property from being considered as "resources" for purposes of eligibility of individual Indian for Medicaid and CHIP
    - 5006(c), Codification in law of current policy which protects certain Indian property from Medicaid estate recovery
    - 5006(d), Protections for individual Indians and Indian health care providers in states which operate Medicaid through managed care organizations
    - 5006(e)(1), Continuation and expansion of TTAG chartered by CMS
    - 5006(e)(2), Requires States to consult with I/T/Us within the State on proposed changes to Medicaid and CHIP programs
- The Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3 (Feb. 4, 2009)
    - Section 211 makes tribal enrollment document the equivalent of a U.S. passport for the purpose of proving U.S. citizenship for Medicaid eligibility.
    - Section 202(a), to improve access of Indians to Medicaid and CHIP, requires CMS to encourage States to provide for enrollment services on and near Indian reservations.
    - Section 202(b) makes the 10% cap on State CHIP outreach expenses inapplicable to expenditures for outreach to Indian children.

The Centers for Medicare and Medicaid Services (CMS) implements the Indian managed care protections. CMS requires freedom of choice and for AI/ANs who wish to enroll in an MCO to be allowed to do so. CMS' managed care rule at 25 C.F.R. 438.14 codifies the ARRA Indian managed care protections. CMS further does not permit states to require mandatory enrollment of AI/ANs through a SPA due to SSA 1932(a)(2)(C), and CMS has never permitted a state to require mandatory enrollment of AI/ANs through a Section 1115 waiver. CMS requires states to ensure their managed care plan agreements require the MCOs to follow the Indian managed care protections. When a state does not require the MCOs to pay Indian health care providers at the OMB rates, CMS requires the States to make a wrap payment to IHCPs to make them whole. CMS has required states to require that MCOs offer to contract with IHCPs in their area and has developed an Indian managed care addendum for MCO contracts with IHCPs that CMS encourages states to require for contract execution.

Although both Congress and CMS have recognized that Indian managed care protections are important, they are not considered to be exhaustive and do not solve all the issues with managed care in Indian country.

Oklahoma has an opportunity to design a system that complements the Indian health system, rather than one that creates barriers for AI/AN patients. The Indian managed care protections

are important for AI/ANs who elect to enroll in managed care, but they are not the best solution for state or the Indian health system in Oklahoma. The Indian managed care protections take specialized knowledge and the administrative complexity to implement on the part of the State in its oversight of MCOs and on the part of the Tribes in working with the MCOs, the State and CMS.

A better solution is to enhance the care coordination models that have already been developed in the Indian health system that address the uniqueness of our people in Oklahoma and that would result in improved outcomes, engagement and tracking for our high-risk population. Tribes would like to work with the State to create a patient-centered care coordination model specific to the Indian health system that would work for IHS, Urban Indian programs and Tribes, regardless of their size. This would provide incentives to enhance care coordination between IHS, tribal, urban and outside providers for AI/AN Medicaid participants. IHCPs are most familiar with local resources, services available and Tribal culture. CMS has approved similar waivers like the Arizona Indian Medical Home model, and others - examples that have been provided during workgroup meetings. The state could also construct the model to allow IHCPs to provide any enhanced services that the new managed care program might include.

Once in place, the state would not be required to spend resources routinely brokering disputes between MCOs, the Indian health system and CMS - something we have witnessed happen in other states, even states that have had managed care for decades. It is a cyclical set of problems that never really go away. Such a model should increase patient care and health outcomes at no additional cost to the state. It would also allow the state to streamline the identification of services reimbursed at 100% FMAP and more accurately claim the full match. If claims are paid or partially paid by a MCO to IHCPs, there is much more administrative burden in identifying and claiming the full FMAP, likely resulting in lost revenue back to the state. Such a model would eliminate duplication of services for the patient in coordination of care, and for seeking referrals and approvals for higher levels of care, where the patient must navigate the first level of referral/approval at the IHCP, and then be forced to wait for duplicative approvals by a MCO.

Tribal Consultation must be no less than 60 days. As discussed above, Governor Stitt first announced the State would be seeking proposals from MCOs to move the SoonerCare program to managed care on June 18, 2020. On June 23, 2020, Dana Miller, Director, Tribal Government Relations, OHCA provided tribal notice of the decision to seek proposals from MCOs and move the SoonerCare program to managed care in I/T/U Public Notice 2020-06. Ms. Miller convened a tribal MCO workgroup which has now met twice and discussed many but not all the issues outlined in these comments. In a subsequent email notice to the workgroup, Ms. Miller announced that public comments on the MCO proposal will be accepted until 5 pm August 17th.

We note that August 17th is the due date for public comments on the waiver and submit these comments through that process. However, that is not the end of the Tribal consultation period, and we request that the Tribal MCO Workgroup continue to meet to discuss the issues raised in these comments and in those raised by other Tribes. As you know, the State Plan requires at least 60 days notice and comment period for Tribal consultation under normal circumstances. While the State Plan does allow shorter tribal comment periods in abnormal circumstances, the

I/T/U Public Notice 2020-06 does not announce a shorter comment period or invoke the abnormal circumstances provision in the State Plan. As a result, we anticipate being able to continue tribal consultation on this issue for at least the full 60-day period and look forward to continued productive discussions.

Conclusion. Given the uniqueness of the Indian health system, as well as significant complexities in administering the Indian managed care protections, we strongly urge the OHCA to: (1) Not auto-enroll AI/AN into managed care; and, (2) Create an Indian patient-centered care coordination model as described above. We further request follow up meetings through the OHCA/Tribal Workgroup and Tribal Consultation on the issues presented herein.

Thank you for the opportunity to provide comments and recommendations, and we look forward to further collaboration on a productive and effective model for the SoonerCare program.

Sincerely,

Gary Batton, Chief
Choctaw Nation of Oklahoma

cc: Dana Miller, Director, Tribal Government Relations, OHCA

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August 17, 2020

To:
Oklahoma Health Care Authority
Procurement@okhca.org

Commenters:
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Vatsala Pathy, Vice President of Regulatory Governmental Affairs
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4760 S. Highland Drive #217
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801-205-0770

Re: Collective Medical Response to OHCA SoonerCare RFI 80720200002

To whom it may concern:

On behalf of Collective Medical (Collective) it is our pleasure to submit comments in response to the Oklahoma Health Care Authority's Request for Information regarding potential advancements in the SoonerCare Medicaid program. We commend the attention to efficiency, innovation, and patient outcomes in this RFI; we believe that by seeking this information, Oklahoma is on track to achieve an increasingly holistic and compassionate approach to healthcare that will make the most of the state's resources while also optimizing patient outcomes.

Collective operates the largest real-time care collaboration network in the United States. Using unique technology, Collective unifies a patient's entire care team—including hospitals, primary and specialty care, post-acute care facilities, behavioral health providers, community service organizations, and health plans—to collaborate for the good of the patient. Because of our work with providers and care teams across the country, we are acutely aware of the challenges state Medicaid agencies face as they must make the most of every resource to care for the most vulnerable Americans, those with the most complex cases and the highest level of need. Throughout this response we refer to data sharing platforms or healthcare interoperability solutions; both refer to networks like Collective's and their tools for surfacing, prioritizing, sharing and analyzing the information available there.

Because Collective is not a health plan organization, we restrict our comments to those questions on which we have specific knowledge stemming from our years of work in the field of healthcare interoperability and information sharing.

Benefits Provided Through MCOs

What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Opportunities for integration across the care continuum open up dramatically with increased opportunities for high-quality communication among providers and payers. Emergency department overuse is one area many systems choose to target using a data sharing platform, and this can be a fruitful place to catch opportunities to improve efficiency, experiences and outcomes surrounding behavioral health patients.

One common scenario is that of a patient in a behavioral health-related crisis presenting in the emergency department, needing care. With no background or communication, the ED staff has to fly blind with a patient in distress, with risks they don't know about, likely unaware of diagnoses or care history. With a robust data-sharing platform, however, the ED staff might have some or all of the following advantages:

- A one-page notification that surfaces the patient's main diagnoses, including mental illness if applicable, COVID-19 testing status if applicable, history, and medications
- A warning if the patient has a history of security incidents
- A Care Insight (unique to Collective) from the patient's primary care provider with personalized notes about the patient's needs and preferences
- Information about the patient's interaction with certain community supports, such as the patient being on a HUD assisted-housing voucher waiting list
- Information from Substance Use Disorder providers, depending on patient consent under 42 CFR Part 2 (Collective offers a Consent Module for this purpose)
- Alert sent to the patient's behavioral health provider so that they can follow up—or even intervene immediately, in some cases
- Alert sent to the patient's primary care provider so that they can follow up
- Alert sent to home health or skilled nursing, if applicable, so that they can collaborate to avoid unnecessary hospital admission or readmission
- Alert sent to the patient's payment source so that they can ensure the patient is seeking care in-network and engage care management when needed

The alerts mentioned here are sent within minutes into the recipients' chosen means of delivery—text, e-mail, even directly into an EMR trackboard. When information is shared in real time with the entire care team, true collaboration becomes possible in a way that would normally require the entire team to be housed under one roof. The role of primary care becomes more equalized with the rest of the team—they have the same opportunities to send and receive information as hospital staff, behavioral health, or payers.

Collective therefore recommends that care integration rest upon a solid data-sharing platform with robust capabilities for communication among the entire care team. Our customers have seen significant success using this approach:

- Virginia's Emergency Department Care Coordination (EDCC) program, launched in the summer of 2017, helps ED staff identify if a patient has been seen somewhere else, how they were treated, who their primary care provider is, and if they've had any controlled substances prescribed to them. Giving medical providers access to critical patient information in real time has helped decrease fatal opioid overdoses from 1,230 in 2017 to 1,213 in 2018. Additionally, all fatal drug overdoses in Virginia dropped from 1,536 in 2017 to 1,484 in 2018.

- Aspire Health Alliance runs a behavioral health program for Massachusetts' Medicaid program, MassHealth. The program is opt-in only, which meant traditionally participation rates were averaging 10 percent. With expanded data sharing capabilities, Aspire case managers receive real-time notifications and can follow-up with patients while in the ED, instead of contacting them down post-discharge, leading to a 50 percent opt-in rate for behavioral health programs when patients are engaged in the ED, and an overall 35 percent participation rate.

How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

Collective encourages OHCA to refer to the Medicaid Innovation Accelerator Program webinar, "Leveraging Managed Care Contract Language to Improve SUD Purchasing Strategies,"[1] which provides a number of detailed strategies that OHCA may consider for how MCOs can support, shape and improve provider performance to expand access and improve outcomes for individuals with substance use disorders. As the purchasers of SUD services, the OHCA and its MCOs have an array of tools that can shape providers' ability to improve SUD treatment and outcomes. For example, they can establish standards of care and benchmarks for medical necessity criteria (such as those recommended by the American Society of Addiction Medicine), provide technical assistance to providers, establish an adequate network that includes SUD providers, and establish quality measures and performance incentives linked to SUD outcomes.

Real-time data and alerts delivered to the right care team members at the right time can be an incredibly useful tool for provider efforts to expand access and improve outcomes for individuals with SUD and OUD. This type of data sharing allows interventions to occur at critical moments so that patients can be engaged or re-engaged in treatment. MCOs can support provider performance in this area by

- Adopting infrastructure and capacity for robust data sharing with and between their network providers (within the parameters of 42 CFR Part 2 data sharing restrictions)
- Collaborating with providers to develop and implement workflows and best practices for delivering treatment to individuals with SUD
- Encouraging or incentivizing their network hospitals, outpatient providers, SUD clinics and treatment facilities to connect and participate

Collective Medical, with our focus on clinical interoperability, can be a valuable partner in these efforts and brings a vast network of providers from within Oklahoma, from neighboring states, and from across the country. The Collective platform connects and empowers providers to identify and support patients struggling with SUD. It connects patient utilization and prescription histories across providers and care settings to flag patients at risk for substance use disorder; it then delivers a condensed view of key factors that could be contributing—including mental or behavioral diagnoses or social determinants of health information.

Additionally, MCOs contribute information from their longitudinal records, including filled prescriptions and social determinants, to provide a more complete picture of the patient. For example, MCOs can deploy a "Triple Threat" flag using our platform, which indicates when a member is on a combination of three drugs (opioids, benzodiazepines and muscle

[1] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/nds4-managed-care.pdf

relaxants), because this combination places them at a very high risk of death from overdose. MCOs have this information through claims data when an ED physician may not, unless the patient divulges that information.

MCOs can also provide tools, technical assistance and information to help providers connect and collaborate with other resources on the path to recovery, such as SUD clinics, behavioral health providers and community resources. Collective recommends the adoption of an advanced data sharing platform with a broad network of providers that facilitates this process.

One example of our SUD program successes is Hardin Memorial Hospital (HMH) in Kentucky, which has used Collective's platform to connect to local SUD clinics such as Stepworks, a treatment and recovery center with five locations. The Stepworks care manager gets a real-time notification when one of their patients is in the HMH ED, which allows them to reach out to the ED social worker and meet the patient at the ED before opioids are given. Stepworks is able to intervene before the patient leaves the hospital and in all but a few cases, these patients have chosen to re-engage in treatment. Similarly, the use of Collective's platform has helped boost retention rates for medication assisted treatment (MAT) programs for Bartlett Regional Hospital in Alaska, to achieve a 63.6 percent retention rate—15 percent higher than the national average.

Care Management and Coordination

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

A patient's journey through behavioral health managed care networks can be fragmented and disconnected. Requiring all participating plans to implement an advanced data sharing solution would powerfully leverage existing care and service coordination efforts in Oklahoma communities and encourage the formation of new collaborative relationships to serve patients. Every person we speak with in the caring professions has entered their field to help and serve others. One of the most important things OHCA can do is ensure that these professionals have the best possible tools to do the work they feel called to. We believe that kind of empowerment often helps individuals find intrinsic motivation as they see more positive results from their day-to-day efforts.

Infrastructure that includes technology like ours is vital for the new era of whole-patient care, both for pushing toward goals with each patient or encounter, and for reporting and accountability. We therefore recommend that OHCA implement a data sharing platform to support a stronger care network, more efficient and effective care delivery. Any platform chosen for use must demonstrate sufficient flexibility to be configured and implemented to support the structure of goals and incentives that Oklahoma chooses.

We have seen success stories using our data sharing solutions to achieve specifically chosen goals at the community level, the health plan level, and even with statewide initiatives. For example:

- Using Collective's real-time, ADT-based notifications, Aspire Health Alliance, a Medicaid health plan in Massachusetts with a dedicated Behavioral Health Community Partner program, has been able to raise patient engagement by 150 percent.
- Northwest Physicians Network (NPN)—an independent physician association in Tacoma, Washington, uses an advanced interoperability solution to collaborate with Pierce County's Mobile Community Intervention Response Team and emergency services to increase efficiency and improve outcomes for patients with substance use disorders, mental health conditions and other complicating factors. This strategy has generated a 44 percent

reduction in 911 calls, a 47 percent decrease in EMS transport, a 36 percent reduction in ED visits, a 42 percent decrease in hospital admissions, and a 31 percent drop in observation stays.

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

In our experience supporting MCOs who manage members with chronic or complex health conditions, early identification and real time management have significantly improved the health outcomes for patients—and their engagement with the MCO and providers. OHCA should encourage MCOs to seek out vendors who can apply real-time evaluation to each encounter as it is occurring and identify plan members who are exhibiting specific symptoms or behaviors that indicate likelihood of chronic or complex conditions. Once these individuals are identified, notifications or working lists can be provided to MCO care managers, as well the member's provider. These may lead to tests that enable a potentially lifesaving early diagnosis, or equally lifesaving improvements in managing a chronic condition based on outreach and education.

Once members with complex health conditions have been identified, MCO care managers should have complete awareness of those members' hospital use in real time. This kind of transparency magnifies a care manager's power to perform outreach and intervention with the member during the first few hours after discharge. A care manager's prompt action on a simple email or text message indicating their member is in the ED can significantly improve the engagement between care manager and member, also allowing care managers to provide the much needed support and resources to the member during their most high risk period of readmission. Follow up from a care manager weeks later simply does not have the same impact; by that point members have often shifted to focus on other issues in their lives or the memory of their hospital visit may have begun to fade. Real-time is key for MCO care management.

Using Collective's real-time, ADT-based notifications, Molina Healthcare in Washington state identifies early-onset diseases like CHF, CAD, COPD, asthma and diabetes through a series of criteria logic created to evaluate diagnosis codes, chief complaint, sex, age and prior utilization history. When a member has been identified, Molina reaches out with the goal of enrolling them into a disease management program. Once enrolled, the members are frequently contacted and provided the tools they need to address the varying factors associated to their health condition. In addition, when an enrolled member presents to an emergency department the disease care manager receives a notification and can promptly follow up with the member.

What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

OHCA and MCOs will significantly reduce barriers to care for these special populations by connecting their care teams so that providers, payers and community resources are all playing from a single playbook. Physicians at the hospital should be made aware of care insights from other hospital and ED physicians as well from members' primary care doctors. MCO care managers and the primary care physicians should be informed immediately when members present at the hospital for any reason. Outreach should be made simpler with up-to-date contact information. Care plans should be created and managed so that all who have contact with any member can access the insights created by different providers—this can even be accomplished in collaboration with the members themselves. Behavioral health organizations need inclusion in collaborative conversations as well as notifications for patients whose symptoms, situations or behaviors trigger mental health concerns.

This level of access and notification requires a robust network of collaborating participants. In a privacy and security world where patient data is strongly safeguarded, these types of collaborative networks exist and thrive only when healthcare

systems focus on improving care coordination using established and trusted security protocols. Those kinds of protections are even more important for the most vulnerable patients—those who need and often access the system the most.

Collective has provided the highly secure collaboration platform underpinning care collaboration efforts for vulnerable populations in many communities, including the following.

- Coordinated Care MCO (Centene) in Tacoma, Washington, maintains the statewide contract to provide health insurance for all those served by the foster care system from birth to age 26. Centene uses the Collective platform to monitor hospital use for all their foster care program members. The plan is charged with making sure resources are available to the foster parents and with monitoring for the possibility of physical abuse or drug seeking behavior proxied through the child's hospital encounter.
- In Alaska, Collective partners with the Alaska Native Tribal Health Consortium. ANTHC is a health insurer with a network of hospitals and providers delivering services to more than 158,000 Alaska Natives. The implemented network provides custom alerting on high-risk individuals, ensures the care team is notified when patients present to the hospital, and allows the health plan to be more involved in the patients' care.

We therefore recommend that OHCA formulate its goals regarding special populations and then ensure that any data sharing and care collaboration platform chosen for use can be implemented in a way that will both empower plans and providers to achieve them, and track and report on progress toward those goals.

Provider Payments and Services

What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

The most important strategy we can suggest to support any quality improvement measure included in the shared accountability model is that each provider be supported with strong tools for sharing healthcare information and reporting on outcomes so that performance measures can be accurately tracked, evaluated, and iterated upon so that the system can continue to reach for ideal efficiency, resilience, and patient outcomes. We do not suggest measures for OHCA but rather point to two key Medicaid managed care incentives below, with explanations for how a robust data sharing platform supports achieving each one and measuring its outcomes.

Any data sharing platform chosen for use by OHCA, MCOs or other provider types should be able to adapt to function on par with the descriptions below for any measure OHCA decides upon.

1. *Emergency Department Utilization (EDU):* Assesses emergency department (ED) utilization among commercial (18 and older) and Medicare (18 and older) health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. The observed rate and expected rate is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less emergency department visits than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the emergency department visit rate across all health plans to produce a risk-standardized rate which allows for national comparison.

   How data sharing supports this measure: The data sharing platform works with existing solutions and with hospitals and health plans to determine criteria for high ED utilization. Patients who meet the chosen criteria will be flagged as high utilizers upon presentation to the ED. This should trigger increased collaboration to help meet the patient's

needs in more appropriate care settings—for example, if a patient presents repeatedly to the ED for management of asthma symptoms, they probably need a better connection with primary care for medications and education; if a patient is using the ED for food or shelter, they probably need connections with community resources for food and housing.

2. *Plan All-cause Readmissions (PCR):* Assesses the rate of adult acute inpatient stays followed by unplanned acute readmission for any diagnosis within 30 days after discharge. NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across health plans to produce a risk-standardized rate allowing national comparison.

   How data sharing supports this measure: Readmissions are a perfect case study for a data sharing platform activating an interdisciplinary team across care settings. Consider a patient who is discharged from the hospital to a skilled nursing facility for rehab after orthopedic surgery, then from the SNF to home after their stay there. If the patient has a fall at home and presents to the ED shortly after that last discharge, the data sharing platform can alert the SNF, which can then intervene to prevent a hospital readmission, possibly admitting the patient to the SNF instead, if needed.

Network Adequacy

How should MCOs work with providers to ensure timely access to care standards are met?

MCOs have a wealth of data that can be useful to share with providers as they deliver services. MCO data and claims history, although lagged, is generally the most comprehensive and longitudinal available view of a patient. Sharing this information can allow providers to see the patient's history at the point of care and tailor their treatment accordingly. In addition to claims history, MCOs could share health risk assessment information, which would give providers access to information about social determinants of health and other risk factors they may not be able to access without MCOs' input. On the Collective platform, this information flows into our Insights and Flags features described above, which are embedded into provider workflows and make the information both accessible and actionable.

The Collective platform is designed to flexibly generate alerts for hospital-based, outpatient-based, and plan-based staff using a wide range of criteria, including

- Diagnosis or chief complaint
- Utilization
- Correlated/subsequent encounters (e.g., an ED encounter within 30 days of SNF discharge)
- Demographics
- Events such as a discharge or transfer
- Security and safety events recorded in the Collective platform
- Insights, consisting of shared care plans and care history items

This capability is a function of a sophisticated analytics engine that, combined with Collective's robust enterprise master patient index (eMPI) functionality, combs through Collective's aggregated data of more than 60 million unique patients from

across the country to identify, in real time, patients who meet provider-established criteria. In addition to standalone criteria, such as a defined utilization threshold or a specific condition or disease state, these criteria can also be used in combination—for example, to identify pediatric asthma patients with more than three emergency department encounters over the past month. These criteria form the basis of what amounts to custom alerts that OHCA MCOs could establish in partnership and consultation with the Collective team, which brings extensive experience with a large range of health plans and other risk-bearing entities from across the country.

Administrative Requirements

How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

To achieve OHCA's managed care program goals of emphasizing a personalized care experience, improving wellness and health outcomes, and improving care for children and adults with complex needs, care management information and patient health information will need to be shared between MCOs and their contracted and non-contracted providers. Effectively managing both data sharing rights and privacy concerns is not a simple task, but it can be managed by third-party vendors who specialize in privacy and security. The infrastructure and management of patient data from multiple health plans and health systems as well as thousands of primary care providers requires full time technical support, user support, contracting support and many other services, all dedicated to the streamlining of secure patient information sharing. Health Plans do not need to shoulder this administrative burden when there are HITRUST certified vendors who already have access to hospital encounters, continuity of care documents and care coordination insights in Oklahoma. A vendor qualified to meet this need will have the specialized infrastructure to rapidly deploy and securely transmit data to providers who have a HIPAA-qualified treatment, payment or operations relationship with a given patient.

Based on our experience, the data sharing and care coordination platform should

- Serve as the basis for continuity of care and ensure that complex patients who need support from multiple points of care do not fall through the cracks
- Facilitate the development of a patient-centered care plan that can be followed and updated by all members of the care team
- Ensure care team visibility to solve the "who's on first" problem with respect to lead responsibility for a patient and ensure that care managers, case managers and social workers in diverse points of care do not trip over one another, spin their wheels or duplicate efforts
- Ensure that care team members do not reinvent the wheel because they lack visibility into information like previous referrals
- Avoid duplicate tests and/or re-diagnosing patient conditions, which can be both expensive and frustrating or harmful to the patient

Collective helps health plans and providers with advanced, real-time member identification of inpatient utilization and readmissions, ED utilization, newborns at time of delivery, skilled nursing facility (SNF) admissions and robust historical data.

We encourage OHCA to expect the following from vendors who specialize in data sharing and care coordination solutions:

- Identify and stratify high-risk members through analytics and real-time, intelligently sourced information

- Drive engagement by the appropriate care team members through workflow-integrated, risk-based notifications
- Access current, accurate demographic information about members
- Know instantly when, where and why members are receiving care
- Minimize risk and maximize consistency in patient care
- Improve outcomes by closing care team communication gaps, improving care transitions, and lowering readmissions
- Save costs by minimizing redundancies in care

As well, we suggest that OHCA require plans and providers to participate in care coordination activities that will positively impact patient care outcomes, such as

- Identifying members who could benefit from care or other types of programs and interventions
- Identifying members who are in a care management program that have an acute episode of care
- Coordinating care with providers and other community resources (primary care, post-acute, behavioral health, etc.)
- Sharing workflows to increase efficiencies and drive consistent care plans

What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

The importance of providers participating in the care planning and management of patients is integral to the patient's overall health. Over the past decade, Collective has implemented our data sharing solution to thousands of providers across the country for this very reason and has most frequently faced these 3 common barriers:

- Budgetary constraints
- Technology and EHR integration limitations
- Staffing resource constraints (care coordinators, patient navigators, etc.)

Barrier 1: Budgets. Often we see that administrators, providers, and care managers know that deploying a smart data sharing solution would be an ideal support for their desire to help and care for patients, but in uncertain times, budget constraints may prevent progress. To overcome this issue and encourage wide scale adoption an inexpensive or free version of the data sharing solution should be made available. Unplanned, avoidable medical costs for MCOs' members decrease as the MCOs boost the number of network providers participating in data sharing for improved care management, further alleviating budget worries.

Collective has developed and deployed a no-cost, lightweight version of their solution that enables MCOs to sponsor providers to receive real-time notifications on their patients, view patient records, and collaborate as part of the patient's care team on creating and sharing care plans with the MCO, health systems and other participating providers.

Barrier 2: Technology and EHR integration. Limitations in technology and technical staff resources often form barriers for provider groups who wish to implement solutions into their workflows. To overcome this issue, we recommend that a Software as a Service (SaaS) solution be used. This would mitigate any required hardware or onsite setup. SaaS solutions are often rapidly deployed and require minimal technical support from the provider organization.

Collective has implemented thousands of providers to their SaaS data sharing and care coordination solution, finding a wide range of existing technology and staff in place. We work individually with each organization to ensure the implementation and support experiences harmonize with their resources and needs. Organizations who do have available technical resources can further enhance their experience with native EHR integration.

Barrier 3: Staffing constraints. Lastly, concern continues to rise in healthcare regarding staffing shortages and increased caseloads. Access to patient data by itself is not an effective solution. Providers often have access in one form or another to data repositories or state databanks, but access to data alone for a busy and overwhelmed clinician has often proven ineffective.

The functionality built around the data sharing and care coordination solution needs to be able to synthesize the information and provide the most relevant and desired content to the provider. If providers face the inconvenience of an additional log in to search for information on patients, it will greatly diminish adoption and use of any data sharing and care coordination solution. Push-based notifications with careful criteria set to avoid alert fatigue, to the right person, through the best available mechanism (email, direct messaging, tiger text, daily outreach reports) will be the key to success of a data sharing solution.

Conclusion

To achieve optimal outcomes, Collective recommends that SoonerCare participates with all their provider network as well as community-based service providers using an advanced data sharing platform to create a robust, active network of appropriately shared health information, facilitating a well-informed, highly interactive virtual interdisciplinary care team for any patient who needs it. Our experience shows this will save costs, improve experiences, and most importantly, create better health outcomes for the citizens of Oklahoma.

We appreciate the opportunity to submit our input in response to your Request for Information. Collective would welcome further discussion with you regarding lessons learned from our national network and ways to improve access, quality and outcomes for the individuals for whom you facilitate and provide care. Please do not hesitate to reach out using the contact information provided below.

Sincerely,

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SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

1. Managed Care Enrollees

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?

  Depending on the success of managed care implementation for the age ranges of 19-64, MCO's could feasibly take on the ABD population & other excluded individuals 12 months s/p initiation.

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

  Allowing MCO's to select certain populations could pose a complicated set of circumstances in that, if one MCO was awarded the target group a monopolized market would exist whereby the members do not have options to choose a plan that fits their needs, budget, etc.

  On the other hand, if a proposal by an MCO for a special group seems to be a more tailored "better fit" proposal for the target audience than what can be provided by other comprehensive plans then it might be in the best interest of OHCA and its future members, providers, & stakeholders to allow this type of carve-out.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

  Incentives for:

  - Scheduling annual checkups (& keeping appointment) – No copay for this visit
  - 100% compliance with all appointments (like perfect attendance) – Rx gift certificate
  - No ER visits or IP admits in 1 year (like auto-insurance accident forgiveness) – Reduced premiums on next year's open enrollment.
  - No cigarettes for 1 year and every year thereafter - Discounts to gym memberships
  - Weight loss, target weight management – Food stamps, Discounts @ Farmers Mkt

2. **Benefits Provided through MCOs**

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

  Insure that MCO's establish Easy & Quick same day appointment scheduling options for members with the Providers that join the MCO's Network

- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

  HIGH Quality Case Management with proven strategies for effective outreach efforts, a.k.a. collaborate efforts with existing in-state Case Managers who have built rapport with the at risk populations.

- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

  Coordinate with in-state Case Managers who have established relations with public assistance programs and who have extensive documentation on such measures

- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

  Primarily, require screening tools to be administered < or = to 1 q 12 mo., i.e. MDS, PHQ9, GAF, GAD, etc., Secondary to the screening tools, contract with local OP psych. facilities to offer treatment, & therapy for the purposes of increasing scores & improving lives

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

  If an MCO can execute a subcontract with Uber &/or Lyft that allows for easy communication with drivers regarding non-acute medical transports and the MCO can establish a level of accountability with drivers for failed transports it could work very well. However, if either of these two components cannot be fulfilled it will not likely yield measurable positive results. Ride sharing could be a good option, but only if it can be monitored & a measure of accountability for drivers can be established to mitigate multiple riders with conflicting health concerns.

3. **Quality and Accountability**

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?

  Monetize positive outcomes related to member improvement in stratified outcome measures for specific health conditions. Include four or more acceptable levels of improvement for specific diagnoses (e.g. top 10 diseases of Oklahomans) and a corresponding incentive. Example; 4 outcome levels of COPD management with 4 accompanying levels of incentive based payouts:

  - Level 1 = Increased understanding by member of disease progression coupled with measured medication compliance; $2 pmpm
  - Level 2 = Increased number of clinic visits to PCP of specialist (decrease # of clinic No-Show appointments); $4 pmpm
  - Level 3 = Measured decrease in the number of visits to Emergency Dept. for acute exacerbations (< 2 per year) for severe chronic conditions, followed closely by a similar decrease in hospitalization rates or re-admission rates (< 2 per year), $6 pmpm
  - Level 4 = No ED visits or IP admissions for 12 months or more; $8 pmpm

- What are the most important indicators of MCO performance? Why?

  Member/patient engagement. Establishes rapport & trust

- What measures of health outcomes should be tracked?

  Number of contacts prior to member/patient engagement. Goals for member/patient after engagement. Progress of member/patient goals. Number of contacts during engagement as a measure for successful goal achievement

4. **Care Management and Coordination**

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?

  Utilization Management tools need understanding by members and providers to achieve the greatest possible outcomes.

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

  MCO's should require & provide (Free of Charge) education to provider groups about how their individual UM process works. Especially when each MCO will likely have variable guidelines that differ from other MCOs. Then MCO should provide evidence of such training to OCHA, OSDH, and State of Oklahoma Commissioner of Health.

- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

  Better access to care. No co-pays for PCMH visits (a.k.a. clinic visit) for both wellness visits and sick visits, as an incentive to not go to ED/ER for non-acute healthcare issues.

- How can MCOs improve the management and coordination for members with chronic or complex health conditions?

  Better access to care. No co-pays for PCMH visits (a.k.a. clinic visit) for both wellness visits and sick visits, as an incentive to not go to ED/ER for non-acute healthcare issues.

- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

  Establishing good relations with community health care partners

5. **Member Services**

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?

  # of PCMH (clinic) visits vs ER a member has (monthly, quarterly, and annually)

- How can MCOs best serve individuals who primarily speak a non-English language?

  Establishment of a language line

  Individuals who may not understand health care terminology?

  Use of Care Managers in conjunction with an established language line

- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

  Est. virtual visits protocols for PCMH visits (office visits) without an accompanying co-pay

- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

  Landline telephone communications. Mail communications. Quarterly town hall in-services by county.

- How can MCOs communicate with members and receive regular input and feedback on program improvements?

  Follow up with members' status post PCMH visits

- What tools and resources would help members search for providers?

  MCO Directory

  What information should be provided?

  Website & mail outs

6. **Provider Payments and Services**

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?

  Provider Service feedback to OHCA.

- Should OHCA require MCOs to maintain a minimum level of reimbursement?

  Yes, at a minimum should be same as level/s est. by OHCA now.

  How should this be accomplished?

  Same as OHCA conducts now.

  How should the state sustain provider compensation?

  Maintain compensation as is currently provided by OHCA, but require MCOs to share cost.

- What is appropriate for timely payment of claims?

  Same as currently est. by OHCA, (bi-weekly?). This is an incentive for Providers to receive payment for claims with expedience.

August 21, 2020
Oklahoma Health Care Authority
Procurement@okhca.org

Re: HHAeXchange Response to Request for Public Feedback 80720200002

To whom it may concern,

Homecare Software Solutions LLC (d.b.a. HHAeXchange or "HHAX") is an industry-leading Homecare Network Management Platform. Our solution prevents inappropriate billing/payment, safeguards against fraud, waste, & abuse (FWA), improves program oversight, and enhances quality of services for members. The HHAX team shares Oklahoma's values in our commitment to improving healthcare operations, containing costs, and protecting the integrity of healthcare programs. We are well qualified and eager to support the State in providing feedback specific to Quality and Accountability; Care Management and Coordination; Member Services; and Provider Payments and Services.

HHAX currently provides a Homecare Network Management system and EVV solution for all three Managed Care Organizations (MCOs) participating in the Pennsylvania Community Health Choices Program (PA CHC). More importantly than the fact that **all three PA MCOs independently evaluated and selected HHAX EVV in a highly competitive field**, we are most proud of the fact that we successfully onboarded over 400 Long Term Services & Support (LTSS) providers and more than 13,000 PA LTSS Medicaid participants in Southwestern Pennsylvania in just a few short months in one phase of our deployment. Total deployment in the State of PA has now exceeded 1,300 homecare providers and more than 100,000 members.

In Florida, HHAX is working with four MCOs and one Third Party Administrator, including our national partners WellCare, Centene, Humana, and Molina, covering 900 providers and over 38,000 members to provide free EVV tools. The MCOs will have full jurisdictional view of their providers, giving them network oversight, compliance, operational efficiency, and payment integrity. Similar to Pennsylvania, the **Florida MCOs independently evaluated and ultimately saw the benefit in working together and bringing HHAX to their provider networks**. We work closely with both OLTL in Pennsylvania and AHCA in Florida to ensure that they are receiving the aggregated EVV files from providers in the State. Additionally, we provide added reporting mechanisms as necessary, such as Missed Visit Reporting, including COVID-19 specific reasons, and other key metrics requested.

We go beyond other vendors' approaches to a regulatory Homecare Network Management and EVV system, treating it as a critical part of a larger mechanism:

- Our internal communications network allows secure, Health Insurance Portability and Accountability Act (HIPAA) compliant communications between MCOs and provider agencies
- Our jurisdictional system affords the ability to broadcast referrals and authorizations automatically, and then have full, real-time visibility into the services provided
- We fully integrate members' Plans of Care to monitor the delivery of specific service tasks
- HHAX manages scheduling and services against Medicaid-provided authorizations
- Our series of built-in auditing filters ensures that submission of claims to Medicaid for payment occurs only for valid claims
- We provide comprehensive performance analytics covering clinical, financial, and operational issues
- HHAX includes real-time alerts to help provider agencies fully comply with all program rules and regulations
- Our platform allows for the capturing of key value-based care data in the home while the caregiver is clocking out

The State's primary goals are to improve health outcomes for Oklahomans, transform payment and delivery system reform statewide by moving toward value-based payments, improve member satisfaction, contain costs through better coordinating services, and increase cost predictability to the state. The HHAX team shares similar values in our commitment to improving healthcare operations, containing costs, and protecting the integrity of healthcare programs.

Our payer management system combines a secure, robust member and authorization system with complete EVV remote data acquisition, which provides a complete jurisdictional view into healthcare services, from authorization to claim payment. HHAX delivers the following benefits:

- Provide flexibility, security, and automation
- Enable comprehensive reporting
- Combat fraud, waste, and abuse

In support of our mission to improve the quality of member care and improve outcomes, HHAX has partnered with Care Heroes, an innovative platform that supports providers and caregivers providing personal home care services to Managed Medicaid and Medicare Advantage populations. Care Heroes enables caregivers to report care delivered in the home, communicate with care managers, and be incentivized for quality patient care and outcomes. Family members are connected directly with payors and care coordinators to report real-time care logs and member updates. This critical caregiver data is integrated with health plans, EVV (electronic visit verification) and other technology platforms to deliver a comprehensive, quality-based care program that improves member outcomes and incentivizes top quality providers.

The Care Heroes platform aggregates personal care agency data and family caregiver logs so that payors and health systems can develop quality incentive programs. Through Care Heroes, agency and caregiver activities are recognized and caregivers can be incentivized for care that improves member outcomes, including reducing hospital readmissions, fall prevention, medication adherence, Social Determinants of Health (SDOH), and quality of life at home. Caregivers can earn care coins based on reported information and achieving established member outcomes. The Care Heroes mobile application allows paid caregivers to redeem earned care coins for items such as Wal-Mart gift cards, gas cards. and access to telehealth.

We appreciate the opportunity to support the State through the sharing of our direct experience in successful state-wide Homecare Network Management and EVV system deployments that require collaboration and open communication between multiple MCO clients. HHAX welcomes the opportunity to come to Oklahoma City or setup a virtual meeting to answer questions about our unique offerings as well as share our detailed experience in the Commonwealth of Pennsylvania. Please do not hesitate to contact me via telephone at (704) 906-6185 or kglenn@hhaexchange.com with any questions.

Thank you for your consideration.

Sincerely,

Kimberly D Glenn

Kim Glenn
SVP Government Health Plans

Quality and Accountability

What mechanisms should the state use to incentivize MCOs to improve member outcomes?
Mechanisms for incentivizing MCOs to improve member outcomes should include the aggregation of EVV data so that it can be properly combined with other member related information including claims data.

In our partnership with Care Heroes, HHAX has created the only platform that leverages our EVV/caregiver reported data and combines it with the Care Heroes proprietary AI/NLP systems so that MCOs can access member needs and potential risks immediately and in real time.

In addition, we have the ability to deploy a unique incentive program for contracted agencies to implement that supports and recognizes paid caregivers. Such incentives are tied to established member outcomes such as member satisfaction, ER admissions, and fall prevention. Other incentives can include encouraging caregivers to participate in additional training specific to member diagnosis that will increase member outcomes.

What are the most important indicators of MCO performance? Why?
The most important indicators of MCO performance are timely communication, care coordinator response time, and additional support for member benefits. These three indicators contribute directly to member satisfaction as well as the quality of care provided.

What measures of health outcomes should be tracked?
Member satisfaction, healthy days at home (how long member is home independently), hospital admissions, falls, skilled nursing facility admissions/length of stay, and access to SDOH support.

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Care Management and Coordination

- **What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?**
- **How can MCOs improve the management and coordination for members with chronic or complex health conditions?**

Industry experience and best practices have shown that instilling an environment of choice and ownership of tools at each stakeholder level is critical to a successful ecosystem. Each provider and each MCO have varying business needs and unique requirements. While on paper it can make sense to require one tool or system for all stakeholders; unfortunately, this often leads to abrasion and pushback as certain tools will provide different features and functionalities. In addition, each entity will have business goals as well as existing systems and tools that if not taken into consideration will create more administrative burden to meet a standardization requirement.

One such example of this is the MCO choice with Provider choice model for Electronic Visit Verification. Given choice to both groups results in the greatest chance of success as it takes into consideration the unique business needs of each stakeholder group. In order to balance the needs of the State, SoonerCare MCOs, and Provider Networks, and ensure a smooth roll-out, it is a best practice and critical to the project success to work with and include the State's MCOs as often as possible in the project, while also directing the MCOs to procure their own Homecare Network Management and EVV system that meets each MCO's unique business needs. If MCOs simply rely on the State's chosen solution, payment integrity can be lost, leading to more fraud, waste, and abuse.

Another crucial element to the success of EVV is to have the State agency clearly define EVV related contractual requirements for the SoonerCare MCOs at the contract onset.

Open Model EVV System with MCO and Provider Choice

As mentioned above, the success of Open Model environments and the EVV market in general have shown that the best way the industry can continue to grow, evolve, and improve care to Medicaid members is through an Open Model that specifically allows for MCOs to choose the vendor that best meets their business needs as well as the Providers having this same choice. This setup is the only way to achieve a least burdensome approach for providers while also allowing MCOs the ability to have oversight of their provider networks and run their system. MCOs own the claim payment process and the provider network. In order to have a successful EVV implementation, the providers need to be seen as partners in the process, which can only occur with open communications and including the MCOs and the Providers in meetings, as well as ensuring choice for both stakeholder groups. Making the MCOs responsible for their provider networks is critical to a successful EVV implementation.

When a state requires or takes on the added cost to allow the MCOs to only use the contracted Aggregator's System, the MCOs often become a gap in the process, as the data is generally coming from the providers straight to the aggregator, without any pre-bill claims scrubbing or verification of the visit data from the MCO. The State Aggregator has a contract that focuses on the State's needs vs. the MCOs business needs. Each MCO has different needs and challenges, such as improved efficiency or real time data in the home to achieve Value-Based Payment (VBP) arrangements. Some MCOs may simply need visit compliance, while other MCOs do not have a way to match authorizations and Plan of Care (POC) to visit scheduling. If the State mandates the EVV Aggregator to the MCOs, it may harm the MCOs' abilities to serve members and achieve their specific goals and business needs. The MCOs need to aggregate and do analytics on their own visit data.

While the initial benefit of rolling the MCO system costs into the State's FMAP reimbursement may be positive, the long-term impact may drive increased fraud, waste, and abuse, billing issues, and a lack of claim adjudication. In

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addition, any aggregator solution chosen by the state will inflate costs if they intend to supply MCOs with EVV under the contract with the State. This additional cost is not only unnecessary, but it is not in the best interest of the State or the MCOs.

Pennsylvania Success Story

Pennsylvania utilized the above processes and models with all three MCOs in the state independently evaluating and then selecting their vendor of choice. The MCOs ultimately chose to work with the same vendor, but the State allowed for the option to evaluate and determine the best solution for their company needs and goals. The chosen EVV vendor then led all of the implementation efforts across the State from start-to-finish including provider registration and onboarding, in-person info sessions, live and recorded webinars, and the development of a hosted Support center for the State's providers. The results from this best practice include:

Reduction in Fraud, Waste, and Abuse (FWA) with Advanced Reporting

The MCOs in PA have reduced FWA across their provider networks by leveraging the EVV vendors advanced reporting and business intelligence tools, giving them actionable data at a 30,000-foot view, as well as on an individual provider level. The MCOs were able to reduce their audit workload with preventative compliance tools, rather than correcting them after-the-fact.

Streamlined Provider-Payer Operations

Under the open model approach, the State's providers were able to choose between using the MCO's platform, their existing EVV solution, or a quick-visit entry tool for providers transitioning off paper. By offering multiple forms of EVV, as well as integrations to other EVV solutions, the MCOs were able to strengthen the relationship between them and their provider networks, while also aggregating the data and simplifying submission and reporting to the State. Any industry-leading EVV vendor should also serve as a real-time communication platform with a full audit trail of all payer-provider communications, eliminating the need for phone calls, faxes, and emails.

Improved Member Care

With reporting on the utilization of the authorization as well as missed and short visits, the MCOs are now able to identify non-compliant or poor-performing providers immediately. Armed with this data, the MCOs work with individual providers on compliance and reward those that are providing services according to the member's authorization. Additionally, using a case broadcasting tool, they now broadcast open member cases to their entire provider network and match providers based on specific member requirements.

By allowing MCOs to evaluate and select an EVV vendor, MCOs can address their unique challenges that are often different from the challenges faced by the State. As EVV and the Medicaid industries evolve, MCOs will look to utilize the data collected through EVV to benefit members and improve care. Adding additional features and functionalities can be a challenge with a State selected vendor as each MCO may want different variations. Some MCOs have needs to track meals on wheels, wheelchair ramps, among other things depending on what the plan covers. MCOs must have choice in order to be successful in EVV deployment.

Open EDI Integration

To achieve successful interfacing with multiple EVV service providers and technology vendors in an open model, an MCO's EVV solution should deploy a self-service EDI Portal platform. Individual providers access the portal to upload confirmed visits and test the interface until it is correct for processing. At the completion of testing, files start to continuously flow from the third-party vendor systems to the MCO's vendor. As the portal receives data records and determines there are deficiencies, the system returns these records for correction to the provider, with

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the visit then re-sent when corrected; this ensures that the platform and the providers platform stay synchronized, an important benefit to the provider. Any viable EVV solution must deploy this type of self-service EDI integration to be successful in an Open Model system as the number of providers and various EVV systems in play is simply too large to manage one by one.

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Member Services

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

Technological advancements have created the opportunity to capture change of condition data directly from the member's home. This data can be used to reduce hospital readmissions, track the risk of COVID-19 infection, as well as supporting value-based payment and alternative payment models.

In order to obtain this data, the industry has shown a need to deploy a software platform that can be used by caregivers while providing care in the member's home, during scheduled and authorized visits. It is essential to provide the caregivers with a technology platform that can easily capture the necessary data elements for the advancement of a value and quality reimbursement model. Clinical experts from existing stakeholders, such as MCOs, can provide input into the content of the clinical questions as well as structure and repetition of such questions that can easily be correlated to each member specific diagnosis. The selected MCOs will need to work with the State to help define the change of condition metrics or conditions to be configured within this technology platform. The Caregiver can use telephony or a mobile application to gather the change of condition metrics as part of the clock out process. Empowering the caregivers with this type of technology will improve quality measure scores and ultimately help drive current and future value-based payment methodologies within the State of Oklahoma.

HHAeXchange has designed a platform that provides this type of functionality that is critical to markets that are transforming to value-based payment arrangements for Medicaid Managed Long Term Support Service environments. Using a web-based technology will empower caregivers to notify their agency when something does not seem right, or if there is a triggering event (e.g. a fall) that needs to be reported and captured. Without such a process and technology, the data may be captured but it will be reported in an unstructured way to the agency and managed care plan or State Medicaid agency. A structured process to capture and report the observations and changes in conditions early in the home at the time of clock out will help to avoid unnecessary visits to the ER or even hospitalizations. Training processes and technology solutions are needed to drive a structured and objective environment.

- Homecare workers are integral members of their client's care team
- Homecare workers get to know their clients intimately and understand when things are not right
- A structured process to report these observations can identify **changes in condition** early - helping to avoid unnecessary visits to the ER or even hospitalizations
- Homecare workers are trained to notify their agency when something does not seem right or there is some event (e.g. a fall), but this process can be subjective, and data received is unstructured
- Training, processes, and technology solutions are needed to drive structured and objective reporting

The HHAeXchange Network is the natural platform to collect and share this important value-based information

A platform like HHAeXchange's is a natural solution to collect and share this important value-based information and change of condition metrics. Structure and technology will not only drive better outcomes for members but also increase the caregiver's confidence in their ability to care for their clients. Having a technology platform with appropriate alerts provides a very needed structure for all stakeholders in the homecare ecosystem. An integrated solution for providers and payors enables better outcomes, efficiency, and economic performance across all stakeholders. With a connected homecare platform, the members, caregivers, providers, and payors can have the ability to be compliant, efficient, and visible to all stakeholders in the process.

In summary, the HHAeXchange mission supports the move to Value-Based Payment. Quality-Based Care comes from actionable, real-time data obtained from the caregiver when providing services in the home. State agencies are in a unique position to guide payors and providers alike in the move to value-based payment methodologies.

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Transforming the Oklahoma Medicaid program from fee-for-service to one that supports value-based outcomes will help the State to achieve operational efficiencies, increased compliance, and improve patient outcomes in line with its Guiding Principles. More importantly, it will help to ensure the long-term sustainability of the system by fundamentally changing the way that providers and managed care organizations deliver health care services in the community. HHAeXchange is strategically aligned with Oklahoma's Guiding Principles and can provide transparency on key performance measures in the home to meet the high standards of patient-centered care across multiple care settings. We welcome the opportunity to engage with key State leadership in a deeper discussion on this topic.

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Provider Payments and Services

What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?
In working with many MLTSS plans and seeing overpayments for claims that do not reconcile against the Cures Act, best practices dictate that the state require the MCOs to have a pre-billing review process that ensures Cures Act compliance with the necessary six data points. These pre-pay claim edits must include LTSS service codes. This will make certain that the State does not have to chase overpayments.

Industry-leading EVV vendors should provide a balance to the complexity found in adhering to the federal EVV mandate to reduce fraud and the overall goal of improving outcomes for the growing number of chronic patients in need of homecare services. The selected EVV solution needs to provide payers with oversight and prevent fraud, waste, and abuse, while helping providers to better meet Medicaid requirements and stay within authorizations to ensure prompt delivery of payments.

MCOs can reduce FWA across their provider networks by leveraging an EVV vendor's advanced reporting and business intelligence, giving them actionable data at a 30,000-foot view, as well as on an individual provider level. MCOs should also validate billed services according to the individual's authorization and the MCO's required scope, duration, and frequency of service. This ability strengthens quality assurance for PCS by improving health and welfare of individuals by validating delivery of services. The MCOs get real-time insights into the services provided to their members, including EVV compliance, underutilized authorizations, missed & short visits, billing, and more.

These important activities and the resulting value are not "just" about mitigating fraud, waste, and abuse. Lowering the incidence of missed or truncated visits and deviations from service plans result in higher quality care. In addition, through the gathering and aggregation of clinical data through these processes, it is likely that the State will gain new insight into the care given and will be able to drive policy, set rates, and consider new value-based payment methodologies.

How can MCOs best communicate to providers about updates and changes to plan policies?
Any technology platform chosen by the MCOs needs to be modular and able to adapt quickly to the changing healthcare environment. This includes the need for MCOs to procure a network management tool that goes beyond simply capturing electronic visit verification (EVV) data for Cures Act compliance. The tool needs to provide a communication platform with real-time notifications and alerts. While a lot of offerings provide reporting on missed visits, or will offer to distribute emails or post updates on a landing page, industry-leading platforms, like HHAeXchange, provide a broadcast ability that allows MCOs to notify their entire network of providers, a subset group of providers, or an individual provider directly within the system. All communications are then auditable and require providers to acknowledge receipt, further enhancing the MCO's ability to ensure that providers have received and read the announcements.

Our communication and broadcasting abilities can be used in a lot of ways to improve communications and relationships between MCOs and their providers. The functionality can be used to send extreme weather alerts, plan changes, as well as announcements, requirements, and guidelines for pandemics, as has been utilized in our system for COVID-19.

In response to COVID-19, HHAX quickly, in a matter of days, developed and deployed tools for provider agencies to ensure open communications and the health of their caregivers and members. With caregivers acting as the first line of defense for some of the most vulnerable and fragile members of our society, we altered our change of

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condition questions in our system to address some of the main indicators of infection. This same approach can be utilized for any future emergencies, or other statewide communications, providing a unique tool to engage the network and provide guidance in difficult times.

The below example illustrates the announcement of new reasons we deployed, after approval from the State Medicaid Agency.

> *Please note that as of Tuesday, 3/17/2020, additional missed visit reasons were added in order to better track and understand missed visits associated with COVID-19. Any missed visits due to COVID-19 should be reported using one of the new reasons added below.*
>
> - *COVID-19: Participant refused and is self-isolating*
> - *COVID-19: Participant is in hospital or NF*
> - *COVID-19: Worker unable to staff because they are sick*
> - *COVID-19: Worker unable to staff because of childcare issues*
> - *COVID-19: Worker switched to cover another case*
> - *COVID-19: Other*
>
> *If choosing COVID-19: Other, please provide additional detail in the Notes section for the missed visit.*
>
> ***Provider Communication**: If you need to send a message to the Department related to a COVID-19 issue, please select the new reason value of COVID-19 and select the urgent message check box.*

As part of the MCO RFP, the State should consider requiring not only COVID-19 specific codes and missed visit reasons, but also a dynamic network management tool that allows MCOs to visualize the impact COVID-19 is having across their entire homecare network, as well as any other emergencies or network policy changes. In addition, this tool should also be able to easily distribute data to the State Medicaid Agency to provide you with actionable insights into the impact of COVID-19 on a statewide basis.

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August 21, 2020

Oklahoma Health Care Authority
Via Electronic Mail to: Procurement@okhca.org

RE: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (80720200002)

To Whom It May Concern:

Amerigroup Oklahoma, Inc. (Amerigroup) is proud to submit our recommendations as a Medicaid managed care organization (MCO) invested in the future of the SoonerCare program. We applaud Oklahoma Health Care Authority's (OHCA's) focus on improved health outcomes and coordinated care as you develop the next generation of the SoonerCare program. As an organization with 29 years' experience serving Medicaid managed care programs across the country, Amerigroup welcomes the opportunity to provide our perspective through this dynamic and collaborative design process.

Amerigroup is dedicated to providing accessible care, improving population health and member satisfaction, and establishing sustainable programs with predictable costs. Our recommendations for the SoonerCare program are based on our organization's experience serving more than 8.1 million Medicaid members in 24 markets. We are committed to the success of OHCA's reimagined SoonerCare program and are excited to share our feedback and suggestions. We look forward to bringing our person-centered model of care to Oklahoma in order to deliver better health outcomes, increase access to care, promote provider collaboration, and ultimately improve the Medicaid experience for all individuals enrolled in the SoonerCare program.

We appreciate the opportunity to respond to OHCA's Request for Public Feedback, and we welcome further discussions with OHCA regarding our program recommendations.

Sincerely,

Elena McFann
President, Medicaid West Region
Anthem, Inc.

Oklahoma SoonerCare Comprehensive Managed Care Program

Managed Care Enrollees

Transitioning Other Populations to Managed Care

- *How and when should OHCA transition ABD and other initially excluded individuals to managed care?*

Amerigroup recommends transitioning Aged, Blind, or Disabled (ABD) and other initially excluded individuals into managed care as soon as possible. This provides individuals who have been diagnosed with physical, developmental, or other disabilities the benefit of MCO care coordination and enhanced supports to address their whole-health needs. This includes early screenings, comprehensive assessments, and integrated care plans based on each member's unique needs, goals, and preferences.

Full integration of all populations and services for these individuals will help avoid unnecessary complexity and costly duplication of administrative services via a common infrastructure for areas such as care coordination, member services, claims processing, and the grievance system. This will also remove eligibility and funding silos that may create barriers to access and improve outcomes and experiences for members, their families and other caregivers, providers, and stakeholders by addressing the challenges in navigating across multiple systems of care.

For more than 29 years, Amerigroup and our affiliates have served members, including older adults and those with physical, developmental, or other disabilities, across multiple states. While we have successfully implemented fully integrated programs in states that adopted comprehensive managed care across all populations initially or within the first year of implementation, we understand that many states may prefer a multi-year implementation approach when transitioning to managed care. For this reason, we recommend that OHCA look for MCOs with experience in delivering integrated services and supports across all program areas and populations. Further, we recommend that OHCA require MCOs to demonstrate their readiness, experience, and capacity to seamlessly transition in additional programs and populations and assess those capabilities through the initial procurement process to assure the selection of MCOs with the necessary expertise and infrastructure for future carve-ins. This will encourage MCOs to develop relationships and invest time and resources from the beginning of implementation to best address the needs of members with specialized needs, their caregivers, providers, and other important stakeholders, assuring a seamless transition to fully integrated managed care according to the State's selected timeline.

Voluntary Enrollment to Promote a Seamless Transition to Managed Care

We suggest that OHCA consider allowing all populations, including ABD and other excluded individuals, to voluntarily enroll in managed care during the initial contract period, even as mandatory enrollment is not yet implemented for these individuals. This approach allows a gradual transition that will help minimize any misperceptions regarding member and caregiver choice as well as concerns related to disruptions in care or reduced access to providers. These are common concerns that arise during a transition to managed care. Voluntary enrollment will give members and families a voice and more choice in the model of care they select. Moreover,

with voluntary enrollment, the State will reap the benefits of a collaborative process that allows for adjustments and refinement through any initial lessons learned rather than transitioning all at once.

While members with physical, developmental, and other disabilities make up a small portion of total Medicaid enrollment, they experience more challenges in accessing care and generally require a greater amount of health care, supportive services, and assistance with social drivers of health. As such, they are also more likely to realize improved access and benefits from care coordination to navigate across providers, waivers and other benefit programs, and multiple systems of care. A fully integrated, coordinated approach under managed care will help maximize the MCOs' value to the State and to the members and families that will be served in Oklahoma.

If OHCA prefers a tiered approach to integration, we recommend the following timeline for ABD and other excluded individuals:

- **Year One.** ***All*** members should be allowed to ***voluntarily enroll*** in at least physical health (PH) and behavioral health (BH) management from the initiation of the managed care program, with mandatory enrollment for all populations for these services to be implemented after the first year. Any long-term services and supports (LTSS) or waiver services would continue to be provided through the fee-for-service (FFS) system.
- **Year Two.** All Medicaid individuals would be enrolled in managed care, including those who have a serious mental illness, those in the ABD population, and those in LTSS and receiving home- and community-based services. The only excluded population from managed care during Year Two would be individuals who are receiving institutional care, such as intermediate or long-term care facilities.
- **Year Three.** MCOs should work with OHCA to structure a transition to a fully integrated LTSS program and to coordinate timing for a Dual Eligible Special Needs Plan (D-SNP).

Enrolling All Populations into Managed Care

- *Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?*

We have found the greatest results in terms of health outcomes, system navigation, and member satisfaction when the Medicaid program is a single, integrated model in which PH, BH, and psychosocial factors are coordinated for all populations across the lifespan. States moving to managed care must assure member choice to meet the federal mandates that require at least two MCOs to participate, which impacts membership volume. MCOs must invest significant time and resources to build and maintain a comprehensive statewide network, administrative infrastructure, and engagement with stakeholders. Enrolling members who have been diagnosed with specialized health care needs into MCOs who are serving Medicaid members helps make sure that MCOs are able to leverage network, access to care, data, and care coordination resources to promote quality care. For this reason, we recommend the State require that each MCO enroll all populations, and any specialty programs should be coordinated by statewide MCOs managing the full range of benefits and services.

Exception: Children in Foster Care

While a sole source managed care specialty program must generally be voluntary to protect member choice, programs for children in foster care represent an exception to this. As the State serves as the custodian for children in foster care and is responsible for making decisions on their behalf, OHCA may choose a sole source managed care model for foster care. We believe a sole source specialty plan will best serve these children, rather than multiple MCOs. This population is relatively small, and a carved-out specialty plan will not impact the sustainability of MCOs within the Medicaid program as other populations would. A sole source approach supports the significant investment and collaborative strategies across the systems of care to strengthen the program and deliver better outcomes for children in foster care. However, we also believe OHCA should select a statewide Medicaid MCO managing the full range of benefits and services to serve as the single, statewide foster care specialty plan.

The single-MCO approach promotes greater stability and continuity of care for children and youth if they move between placements and foster families, and ultimately supports efforts toward permanency. Our experience indicates the single-MCO approach within a larger managed care program is the best model to help members live in their communities, achieve permanent living situations, and develop the life skills they need to be independent, well-functioning adults. Perhaps most importantly, a single MCO will make coordination with child welfare and other agencies more complete, comprehensive, productive, and effective — which will contribute to a more unified system of care for these children. It will also eliminate the need for foster parents to interact with multiple MCOs, especially for those caring for more than one child.

In addition, this model assures more comprehensive services to members, reduces fragmentation, enhances accountability for access to services and improved health outcomes, minimizes administrative burden for agencies and providers, and takes advantage of economies of scale. Conversely, with the smaller number of children in foster care (and with other specialty plan populations), it would be challenging to sustain an infrastructure to provide the appropriate care and services that address members' needs if these children are spread out across multiple MCOs. Having a statewide foundational infrastructure, as well as experience with similar programs, will be critical for MCOs to successfully implement a specialty plan for children in foster care.

We recommend that OHCA conduct a stand-alone procurement for the foster care population either concurrent with the initial procurement or subsequent to implementation, limited to MCOs selected for the core procurement. MCOs should demonstrate their experience and outcomes in managing successful foster care programs.

Engaging Individuals in Their Health Care and Healthy Behaviors

- *How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?*

Research shows that increased engagement is positively associated with improved health outcomes, greater use of preventive services, and lower health care costs[1]. In addition, individuals and families who are engaged in their health care and healthy behaviors experience better outcomes and are more satisfied with their overall health care experience[2]. We recommend that OHCA look for MCOs experienced in developing and implementing strategies for engaging members in healthy behaviors (including seeing a doctor regularly, quitting smoking, and eating healthier, for example). MCOs should design culturally competent, multi-modal, and person-centered interactions and communications, and prioritize members' input. MCO strategies must also reach the broadest audience, including members who speak other languages, members with disabilities, and members who are historically difficult to engage.

Member Incentives to Engage Members

Member incentives are a crucial component of population health management, quality improvement, and member engagement. Our affiliates in other states routinely offer member incentives for Medicaid populations and have found them to be a powerful tool to measurably improve health outcomes and HEDIS® rates. We recommend OHCA require MCOs to offer member incentives that support regular engagement in primary care and healthy behaviors. In addition, providers are vital partners to reinforce messages about healthy lifestyles. If all MCOs are required to offer some type of member incentive by contract, it reduces the guesswork for providers in suggesting to their patients that rewards are available to complete preventive services.

OHCA should expect MCOs to leverage technology that will engage members in earning incentives, while providing alternatives to maximize accessibility for members who may not have easy access to the internet. Incentives can be designed and calibrated to respond to Oklahoma's priorities and promote healthier lifestyles. We recommend that OHCA seek input during the procurement process from MCOs about their experience and plans for improving member engagement in healthy activities.

Personal Connection and Technology Solutions to Engage Members

Foremost, MCOs must understand the needs of individuals served in Oklahoma, their communities, and the unique barriers they face. Successful engagement must incorporate outreach and care management strategies along with incentives, technology, tools, and innovative programs that make it easy and desirable for individuals to engage in their care.

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[1] Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. *Health Aff* (Millwood). 2015 Mar;34(3):431-7

[2] Individual and Family Engagement in the Medicaid Population: Emerging Best Practices and Recommendation. https://www.ipfcc.org/bestpractices/Individual-Engagement.pdf

We recommend OHCA seek out MCOs who offer programs and strategies to improve engagement with individuals by combining technological solutions with opportunities to support individuals with a personal connection. For example, a legally blind member in rural Oklahoma may benefit from personalized assistance in connecting to a provider, transportation services, and home-based care in contrast to a third-time mom who lives in an urban area and has an established relationship with an obstetrician, access to a Wi-Fi connection, and familiarity with navigating the internet to self-manage care. In the first scenario, technology by itself will not engage the member. We recommend that OHCA look for MCOs with proven strategies and collaborative initiatives that reach members in their communities, such as through community health workers. Establishing relationships and trust will allow MCOs to work with people in their preferred way and reduce or eliminate barriers to communication. The best way to reach Oklahomans will require a combination of personal outreach and technological capability.

We suggest that OHCA seek out MCOs who can demonstrate their experience by asking detailed questions in the RFP about member engagement strategies and their effectiveness in improving health outcomes and/or utilization of preventive and wellness services.

Benefits Provided through MCOs

Making It Easier for Individuals 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?*

MCOs have experience in recognizing and overcoming the barriers that individuals face in accessing care. These barriers could include not understanding their benefits (health literacy), a lack of timely access to providers and key support services, an absence of reliable transportation to providers' offices, or the often formidable challenges of accessing health care in rural sections of the state. By identifying members' access to care issues — at the time of enrollment, through assessments of their social determinants of health (SDOH) needs, and through monitoring gaps in care — MCOs can develop targeted responses for individual members that make it easier for them to access health care.

We recommend OHCA consider requiring MCOs to propose solutions to improve access in health literacy, non-emergency medical transportation, and the health care workforce. Without health literacy, members cannot manage their health care or navigate the health care system. Without reliable non-emergency medical transportation, members cannot consistently keep their medical appointments. Without a health care workforce that includes the spectrum of provider types in sufficient numbers and that is enlarged in rural communities, members must either wait an unacceptably long time for an appointment or forego needed health care altogether. MCOs should be able to address these systemic barriers to health care access. Additionally, as there is currently a broadband access crisis in the State, particularly in rural areas, OCHA should require MCOs to detail their strong commitments regarding initiatives they will take to augment State efforts.

Increasing Health Literacy

Health literacy — the ability to obtain, process, and understand basic health information and services required to make appropriate health decisions — is a skill Amerigroup works to improve among its members. Even when health care is available and accessible, states see health disparities and poor outcomes in the Medicaid population because of barriers and gaps related to health literacy. In order to improve the health of a population, awareness of health literacy must be at the forefront when developing communication strategies and member materials. MCOs can play a significant role in increasing health literacy by having a comprehensive strategy in place, which should include training providers on cultural competency, developing effective and culturally competent member education materials, partnering with community-based organizations and advocacy groups, and maintaining one-on-one communication with members. Through the implementation of this type of strategy, MCOs can help members better understand health information, make decisions for themselves, be more involved in their health and well-being, and follow through on their health care goals. When members understand the services that are available to them, they are more likely to access them. For example, when working with enrolled members of an American Indian/Alaska Native (AI/AN) tribal community, MCOs may hire Community Health Representatives who are themselves members of the tribe in order to better engage tribal members and offer culturally competent resources. MCOs can offer trainings that are developed in collaboration with local tribes to better educate providers on customs and practices. They can also develop resources for tribal members that explain the differences between Indian Health Services and managed care so new members can best take advantage of benefits and options.

Facilitating Access to Care by Improving Non-emergency Medical Transportation Services

Reliable and flexible transportation to medical appointments is essential for members to access care. To improve the non-emergency transportation benefit, we recommend having OHCA establish a work group with MCOs to review and discuss the transportation benefit, identifying opportunities to expand access using technology (including smartphone apps) to improve the member experience, allowing providers to schedule rides on behalf of members as part of the appointment scheduling process, and addressing non-emergency medical transportation barriers in rural areas. Our recommendations for improving non-emergency medical transportation access are further detailed in the Benefits section.

Expanding the Care Delivery System Through Workforce Development Initiatives

Increasing the number and types of providers by extending current provider network reach through the use of licensed and non-licensed clinical extenders, such as advanced practice nurses and community health workers, through workforce development initiatives is critical to improving access to health care. We recommend OHCA create a health care provider workforce development task force with the awarded MCOs to identify and document short- and long-term strategies for increasing provider capacity, with special attention on expanding the health care workforce in rural areas. We discuss our workforce development recommendations in greater

detail in the Network Adequacy section. In their RFP responses, MCOs should demonstrate a knowledge of the rural landscape and initiatives focused on workforce expansion in key areas of rural access deficiency.

Expanding Broadband Access to Facilitate Telehealth Services

In Oklahoma, many Medicaid beneficiaries do not have a Wi-Fi connection and cannot easily access the internet. A 2018 study ranked Oklahoma 47th in the nation in rural broadband access. A recent survey by the Oklahoma Department of Education found that at least 167,000 of Oklahoma's 700,000 students do not have internet access at home. Forty percent of Oklahoma households earning less than $20,000 have no internet connection, including through a smartphone. In response to the broadband access crisis in the state, the Oklahoma legislature enacted the Rural Broadband Expansion Act in May 2020. The legislation calls for the creation of a Rural Broadband Expansion Council to study access in the state, including the costs for improvements and developing a uniform statewide system.

Broadband access is vital in rural areas where telehealth has become an important solution to improving access to health care. We recommend that MCOs be required to facilitate access to telehealth by arranging for local resources such as clinics and libraries to offer Wi-Fi and to make private spaces available for member telehealth conferences.

We are aware of a recent decision by the Trump Administration to invest more than $29 million in Oklahoma to provide broadband service in unserved and underserved rural areas in the state. This investment is part of the $100 million in grant funding made available for the ReConnect Pilot Program through the CARES Act. We applaud this investment, and believe that, through partnerships, MCOs can further the goal of increasing internet access in Oklahoma where it is most needed.

How MCOs Can Help Individuals Resolve Problems with Accessing Care

MCOs should be expected to provide the following resources and tools to help members resolve problems with accessing care:

- Member Services staff who are trained to educate members about available community resources and can help members find a provider who meets their needs and preferences
- Community health workers, service coordinators, peer support workers, and care managers who can help link members to services and address barriers such as language, culture, and health literacy
- An easy-to-navigate provider directory that includes comprehensive detail on network providers
- Comprehensive virtual care options to supplement the local provider network and increase access to specialty care

MCOs should provide these kinds of services on demand, by phone, online, and through digital tools.

Strategies to Improve the Integration of Services

- *What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?*

Through this new contract, OHCA has the opportunity to continue to improve the overall system of care by supporting the integration of PH and BH through benefit design, service delivery, and program development. Both PH and BH providers will also play a key role in designing and implementing these efforts.

Historically, PH and BH delivery systems were developed independently (with no formal system-level coordination), leading to fractured service delivery, patient abrasion, and dissatisfaction among both patients and providers. SAMHSA and other nationally recognized organizations have long supported the coordination and integration of PH and BH as the most effective approach to serve individuals with complex care needs. Further, chronic, co-morbid conditions are common — adults with a BH diagnosis are considerably more likely to have multiple, chronic medical conditions than those who do not have a BH diagnosis. These adults also have higher prevalence of tobacco and alcohol use[3].

We know that a fully integrated managed care model offers the most cost-effective solution — from more effective clinical management (to include mitigating medication costs and risks) to delivering operational and administrative efficiencies. As such, in addition to the integration of PH and BH benefits, we recommend OHCA consider the inclusion of the pharmacy benefit for a fully integrated, whole-person managed care model. Central to the goals of a managed care delivery model is the principle that care should be integrated and coordinated across the medical and pharmacy benefits. Carving pharmacy in allows for real-time data to immediately identify potential utilization issues, recognize certain medical conditions, and inform medical decisions. Additionally, given the critical role that the pharmacy benefit plays in a member's overall care, and particularly for co-morbid PH and BH conditions, the integration of pharmacy into the MCO benefit package will allow for the most effective delivery of integrated care. Medicaid programs are strengthened by full integration that allows for more comprehensive services, bringing additional cost savings as well as improved efficiencies to the State.

Additionally, as OHCA moves forward with SoonerCare 2.0, we recommend the following considerations to improve integration of services.

Improving Provider Communication

Fully integrated, whole-person care requires a complete 360° view of member encounters with providers, and affordable and efficient connection between physician practices. Closing the referral loop between PCPs and specialists is a significant step to take. We recognize that cost-effective systems for interoperability is a barrier for closed referral loops. In other states, providers have experienced barriers associated with the cost, required effort, and the utility of a Health Information Exchange (HIE). These challenges are exacerbated for smaller,

[3] Behavioral Health in the Medicaid Program. https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf

independent providers who often lack infrastructure and resources for adoption. Together with OHCA, MCOs can work collaboratively to expand the use of Oklahoma's HIE (for example, MyHealth Access Network) and improve providers' awareness, engagement, and experience while promoting the HIE among MCOs as a vehicle for better coordination and reduced costs. We urge OHCA to require BH and PH providers to communicate with one another about referrals and exchange documents through the HIE to achieve care integration, and to select MCOs that have the experience and care management tools available to help facilitate this exchange.

During the procurement process, we recommend OHCA evaluate MCOs on their technical expertise as well as their various programs and technology designed to support integration, including provider initiatives such as the use of value-based payment (VBP) models. We suggest the State consider MCOs that can bring innovative, pay-for-performance and other quality-based reimbursement arrangements that promote and improve service integration, and that can support providers who participate in these models through data analytics, communication, technical expertise, and training.

Promoting Shared Assessments and Planning

We recommend OHCA partner with MCOs that have the experience, agility, and technology to deliver the right information to providers and stakeholders in a way that supports understanding, coordination, and action. MCOs must have the technology to support and receive real-time admission, discharge and transfer (ADT) information as it supports shared assessments and care planning, which can be facilitated through information sharing workflows with network providers. OHCA should look for MCOs with the technology and technical expertise to incorporate member data from various sources into one dashboard, which will provide a holistic picture of a member. This makes it easy for providers and MCO staff to act with members on closing gaps in care, minimizing duplication, and making sure members get the services they need across the spectrum of care.

Data Sharing and Programs to Improve Integration

The ongoing COVID-19 pandemic has underscored the importance of expedient exchange of current and historical information among health care providers, so they have critical health data when they need it, as part of an integrated service model. Amerigroup supports OHCA's vision for a connected health ecosystem in Oklahoma, which includes a statewide health information network of shared services between existing HIEs so that all system of care organizations can and will participate in data sharing. We recognize that expanding the use of an HIE can include challenges around data governance, data quality, diversity of coding technologies, and the integration of medical and BH information. Our parent company and affiliates support HIEs in multiple other markets, and we welcome the opportunity to work with OHCA to standardize information that is shared and develop policies that encourage information sharing, along with funding assistance to offset providers' fees and encourage participation.

Facilitating and Tracking Social Service Referrals and Outcomes

- *How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?*

Members are best served through a holistic, person-centered approach that engages them as partners in promoting and maintaining their health and well-being and that supports their strengths and needs, including SDOH. MCOs facilitate access to services to address SDOH through a variety of strategies, from call center operations and community engagement activities, to quality outreach and care management interventions. Medicaid members represent some of the most underserved populations, so MCOs who have extensive experience integrating SDOH into their overall care coordination and management programs will be important.

Historically, this coordination has not been traditionally captured or measured as SDOH. Further, many social service systems and community organizations are not at a place to easily track and respond to MCO inquiries regarding services at the individual level. There may also be challenges in IT or reporting structure as well as interoperable systems for data sharing. In addition, social service organizations commonly deliver services to individuals on a first-name basis and consider these services private and protected. All of these factors present challenges in tracking and referrals. We recommend that OHCA look for MCOs who demonstrate extensive knowledge and capabilities to identify and develop assessment tools, resources, and community partners to proactively address the SDOH needs of members, which includes a tracking and referral process.

Facilitating Referrals and Tracking Outcomes

Early identification, outreach, and engagement is key to connecting members to needed services and supports. We recommend that OHCA capture social risk factor data during the determination of Medicaid eligibility and transmit that data through enrollment files for MCOs to access. MCOs will then be in a better position to leverage this data and facilitate referrals more rapidly to support early identification. With access to this information, MCOs can facilitate timely outreach to members who may be more responsive to individual contact and might need help understanding, accessing, and connecting with benefits, services, and social resources. Additionally, this information can be used to help identify specific disparities that can be addressed to promote health equity. As a part of closing the loop on referrals for services, MCOs should analyze claims data for the presence of the new ICD-10 codes for SDOH. Although some community services will not submit claims, claims data provides a good way for MCOs to identify members that are using services to which they were referred.

Understanding that an individual's needs may change frequently, we also recommend the adoption of a simple, standardized SDOH screening tool that can be used to assess member needs at multiple points of contact. This can include MCO-initiated screening and ongoing care management interactions, as well as provider visits, such as annual exams and prenatal visits. Additionally, provider screenings could be shared via HIE so that MCOs can coordinate with providers and assist in referrals and tracking. This simplification reduces the potential for member survey fatigue, and standardization promotes consistent data and reportable analysis

that can improve the likelihood of member engagement in outreach, care and service coordination, or care management.

MCOs must dedicate time and invest in building strong community ties so they can more easily reach members in their communities and facilitate referrals to the social services they may need. An MCO that can foster a strong network of local partnerships with business and community organizations will be critical in coordinating with local resources to improve member outcomes. In addition, MCOs should use local staff who know the communities and resources available, can engage and collaborate on new ideas, and can make sure services are being tracked and received. To that end, we recommend that OHCA look for MCOs that have specialized staff with the knowledge and skills to focus on addressing SDOH.

MCOs must implement referral and tracking solutions that have the dynamic ability to assist members in locating available resources that are specific to their preferences as well as their needs. By using a central application, MCOs should provide members with the ability to conduct searches and make self-referrals, while also enabling staff to use the same integrated system to actively assist members with searches and referrals, identify resources on behalf of members, capture and store referral data and statuses, and track referral outcomes. Other strategies that will help in connecting individuals to social supports include provider incentives to encourage and reward the completion of social assessments, referrals to local resources, and performance plans to track that services have been received.

Measuring MCO Performance

To address the State's priorities and goals, we recommend a collaborative effort between MCOs, State agencies, and local community agencies that can be established based on common goals. Together, these entities can measure specific SDOH initiatives based on expected metrics and outcomes for the members that will be served. OHCA can measure MCOs' performance on mitigating social risk factors by tracking the screening of members for SDOH and the number of referrals made to SDOH services. We support capturing SDOH referral information, and think it will be important to work with the State and community-based organizations to improve SDOH referrals made by the treating providers.

Collaborations should focus on how to best capture the activity data that is already collected, and in turn develop population health approaches in conjunction with providers and social service partners within the community. The best strategies to achieve this include:

- Facilitating information sharing between public, private, and provider sectors through avenues like an HIE
- Capturing SDOH services through the integration of social services systems (as part of an electronic medical record)
- Supporting a closed loop referral process completed during care management or Member Services calls and incorporating these into common measurements such as gaps in care, emergency department or inpatient costs, and medication adherence

Improving Access to Evidence-Based Behavioral Health Care

- *How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?*

The practice of evidence-based care is an ongoing process involving providers and members — staying apprised of the latest best practices, filtering those practices through the member's preferences, and sharing in the decision-making with members and their families are all key components. MCOs can improve access to evidence-based BH care by promoting use of the services, but also by equipping providers with the appropriate resources and network to support referrals when a member is identified as needing BH services. MCOs can proactively take steps to leverage educational opportunities that will inform and train providers on evidence-based practices.

Several evidence-based treatments exist within BH, but studies show that few providers consistently deliver these interventions. Use of outcome measures is limited by lack of provider adoption or technology infrastructure to measure and report outcomes. As a result, less than half of Americans with BH disorders access care. When they do, quality is not typically measured and there is reasonable risk that quality is poor[4]. To improve access to evidence-based BH care, we encourage collaboration between the State and MCOs to incorporate these services into the MCO Medicaid fee schedule.

By collaborating with the State on rate setting and incentives, MCOs can encourage providers to use treatments such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment (MAT), or assertive community treatment. Working together, MCOs and the State can deploy information sharing and payment innovation programs that will help make sure providers are fully aware of and understand the referral path for these services. For example, PCPs are often poised to be early screeners of symptoms that can identify the potential need for referral to specialists and additional services, such as BH or substance use disorder. We recommend that OHCA consider experienced MCOs who have worked with their network PCPs and other providers on using SBIRT to encourage healthy behaviors in their patients, and in connecting them to the appropriate BH providers based on their needs. Additionally, OHCA should consider MCOs with proven expertise in developing a robust BH network along with outreach strategies to promote MAT, expanding access and resources for providers.

Lastly, we applaud the Oklahoma Department of Mental Health and Substance Abuse Services in partnering with the University of Oklahoma Health Sciences Center and their statewide network of providers to initiate SBIRT in more private practices and to increase the availability of SBIRT medical practitioner training across the state. We recommend partnering with stakeholders to work hand-in-hand with Oklahoma's provider community to hold seminars and design educational initiatives that will bring nationally renowned providers and best practices to the State.

[4] Health Affairs. Behavioral Health: A Payer-Based Strategy for Improving Quality and Access During COVID-19 and beyond. https://www.healthaffairs.org/do/10.1377/hblog20200618.440697/full/

Value-added Services That Positively Impact Members

- *What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?*

Value-added services (VAS) cover a wide scope, from easy-to-access lifestyle and healthy behavior programs and tools to more hands-on, intensive supports. They help address current gaps in services and incentivize members to access preventive care, engage in healthy behaviors, and adhere to treatment recommendations. To maximize their impact, we recommend OHCA allow MCOs to propose their own VAS rather than requiring them to select from a pre-defined list of benefits. This will drive competitive differentiation and encourage member self-selection. By avoiding a "one-size-fits-all approach," MCOs will be able to support a fully integrated, person-centered model of care that focuses on a member's individualized needs, preferences, strengths, and goals. We recommend that OHCA look for MCOs who can offer a catalog of VAS options, giving members a choice in selecting the benefits that best fit their needs and aligning with Oklahoma's goals and health priorities.

We suggest that OHCA partner with MCOs who have demonstrated capabilities that offer a variety of VAS designed to improve health outcomes, reduce disparities, and support the State's goals and priorities. It is paramount for MCOs to understand the nuances of Oklahoma and the unique needs of the people who will be served, so the VAS offered are engaging and useful.

To be most impactful for members, we suggest the following strategies related to VAS:

- MCOs should have flexibility in offering VAS and be equipped to provide benefit and eligibility requirements as well as reporting back to the State on annual utilization and spend metrics for those services.
- MCOs must offer true value-added benefits, which exceed contract requirements and do not reflect disease management programs or other standard components of care.
- MCOs must demonstrate experience offering true value-added benefits — ones that are not reimbursed via the MCO capitation payment rate and do not duplicate covered benefits or services already available in the community at no cost.
- Offerings should be available on a statewide basis so that all eligible members, regardless of where they live, have the opportunity to easily access them.
- MCOs should be required to offer any VAS proposed in the RFP for a minimum of one contract year, and then be allowed to add, modify, or delete benefits based on evaluation, and measurements, and member feedback.
- Services must be transparent to members and easily accessible via multiple channels, including the ability to self-select goods and services electronically, the ability to receive additional services from providers, or the ability to call Member Services to obtain information about available options.

Amerigroup's organizational experience providing VAS has given us insight on strategies for engaging members and helping them access the available resources. While member incentive programs may be considered a value-add, we recommend that OHCA integrate a member incentive program as a core program requirement for MCOs. In addition, to complement VAS and increase

access to the services and supports they need, we recommend that MCOs be allowed to offer in lieu of services, which will drive additional cost savings and improved outcomes for Oklahomans. We recommend that OHCA seek information from prospective MCOs regarding proposed in lieu of services within the RFP as well.

Improving Access to Transportation for SoonerCare Members

- *How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?*

Access to safe and reliable transportation is a barrier to health care access in nearly all Medicaid programs. A lack of reliable transportation can lead to missed or delayed medical appointments and negatively affect member health outcomes. OHCA should partner with MCOs who have a proven track record for developing innovative transportation solutions to help meet member needs.

Amerigroup affiliates coordinate a non-emergency medical transportation benefit in 14 Medicaid markets across the country, many with a heavily rural population similar to Oklahoma. Leveraging the experience and proven success in our affiliate markets, we recommend the use of a transportation access work group, education, and vendor collaboration and monitoring for improving transportation access for SoonerCare members.

Transportation Access Work Group

During the regional and tribal strategy forums OHCA held in late 2018 and early 2019, participants provided feedback related to the need for better transportation options and mentioned that the three-day notice requirement was burdensome.

We recommend that OHCA establish a work group with MCOs soon after contract award to review and discuss the transportation benefit and identify opportunities to expand access and provide SoonerCare members with a flexible and reliable service. Pairing OHCA's knowledge of its members and their transportation needs with the experience MCOs have with transportation vendors and coordinating the benefit in other markets can result in new ideas and standards. The work group would also have the experience and expertise to identify solutions to any barriers associated with innovative ideas.

We suggest that the work group review current SoonerRide requirements — such as required notice for scheduled rides, additional passengers, pick-up and drop-off locations, and mileage reimbursement for use of own car — and collaborate to develop a set of consistent and flexible transportation standards that improve access for SoonerCare members.

Some additional options for expanding access to explore with the work group include:

- Utilizing technology (including smartphone apps) to improve the member experience
- Allowing providers to schedule rides on behalf of members as part of the appointment scheduling process
- Leveraging transportation to address SDOH and health disparities, especially those that correlate to the population health goals identified as State priorities (such as rides to child birth classes or addiction recovery support meetings)

- Expanding situations where members can receive mileage reimbursement for using their own transportation
- Collaborating with tribal nation transportation services, such as the Cherokee Nation Transit program, to expand access to tribal members
- Partnering with community groups that may be able to provide volunteer rides to expand the reserve of drivers

Educating Members and Providers

We often find that both members and providers lack a thorough understanding of the transportation benefit and how to use it. MCOs should create specific member and provider education and enhanced awareness campaigns focused on transportation, including leveraging materials like the SoonerRide brochure. Education should include telephone numbers, trip scheduling requirements for scheduled appointments, standing order rides (such as to recurring dialysis appointments), and short notice trips, and other requirements, such as pick-up locations and additional passengers.

Member education should include an array of communication methods, such as use of alternate media sources, community organizations, and pharmacies. When members contact the Member Services Helpline for help with finding a provider, MCOs should proactively query the member about transportation needs and provide information on how to schedule a ride.

Similarly, we recommend that MCOs involve the health care provider in the overall member communication plan to help SoonerCare members understand how to access the transportation benefit, especially when they make an appointment. Providers have the most communication with members, often in person, during which obtaining preferred and accurate communication methods is a straightforward process. MCOs should include information about accessing the transportation benefit in provider education sessions and collaterals and leverage network representatives to reinforce messaging.

Vendor Collaboration and Monitoring

Collaborating with and holding vendors accountable for recruiting and retaining an adequate network of transportation providers is key to address barriers and improve access to transportation for SoonerCare members. Maintaining and improving member access to reliable and safe transportation requires diligent ongoing monitoring of vendor performance. As a best practice, MCOs should create a partnership with transportation vendors that embraces a culture of continuous improvement, seeking out opportunities for innovation and ways to deliver better service.

In the RFP, OHCA should ask MCOs to provide a detailed description of how they will monitor the transportation benefit. MCOs should use a well-vetted transportation vendor and provide a detailed description of how they will monitor the transportation benefit, hold vendors accountable for service level requirements, and address performance problems.

MCOs must require regular vendor submission of detailed network, call center (trip scheduling), and trip data (such as on-time performance), and meet regularly to review performance and opportunities for improvement. To improve access, data analysis should focus on whether the

vendor has sufficient transportation providers to meet member demand. To improve reliability, data analysis should focus on metrics such as travel time, wait time, and timely member pick-up and drop-off.

Additionally, MCOs should consider alternate sources for information on vendor performance, including member complaint and grievance data and feedback from providers.

Use of Ride-sharing Services

We recommend that ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments for SoonerCare members. In nine of our affiliates' Medicaid markets, ride-sharing services are an important way to supplement gaps and bolster the transportation network. Earlier this year, one of our affiliates saw a 42% increase in PCP visits by members using ride-sharing services, and was also able to close 50% of pre-existing primary care gaps.

The ability of some ride-sharing companies to provide door-to-door transportation, in addition to curbside service, can provide additional access for SoonerCare members, especially if OHCA chooses to carve in excluded populations.

Quality and Accountability

Mechanisms to Incentivize MCOs to Improve Member Outcomes

- *What mechanisms should the state use to incentivize MCOs to improve member outcomes?*

With affiliates operating Medicaid programs in 24 markets across the country, Amerigroup has significant experience operating under a wide variety of state incentive programs. We embrace OHCA's plan to incentivize MCOs to improve member outcomes and welcome the opportunity to collaborate with OHCA on the design of an incentive program that drives tangible benefits to the Oklahoma Medicaid program.

MCO incentives can be thought of on a continuum. At one end, a program structured around a quality bonus creates a feeling of partnership between the State and MCOs and acts as a true incentive for improving member outcomes. Additionally, this type of program design will be the most straightforward for OHCA to administer in the early years of working with MCOs. At the other end, a program structured around fines or liquidated damages is punitive by nature. In the middle of the continuum is a capitation withhold program, a common design across our affiliates. An incentive program that includes a bonus for some criteria and a capitation withhold for others may provide a good balance for the State.

We additionally recommend that OHCA consider a number of factors in program design that enable MCO efforts to gain provider support and participation in the pursuit of quality improvement:

- **Measure Type.** Use HEDIS measures of clinical quality because they are readily understood among MCOs and providers as an indicator of member outcomes. We discourage use of State-designed non-HEDIS measures. Use of non-standard measures often adds administrative burden, leading to difficulty making sure MCOs calculate results in the same manner.

- **Number of Measures.** Select eight to ten measures, aligned with State health goals such as healthy pregnancies, tobacco use, opioid abuse, childhood obesity, BH access, diabetes, and cardiovascular disease. Too many measures dilutes focus, and too few will lead to narrow results. Our experience shows that eight to ten measures provides a good balance.
- **Timing.** Finalize program design at least six months before implementation to provide MCOs with sufficient time to plan. In the context of Oklahoma's timeline, we recommend that planning continue in partnership with selected MCOs during the first year of operations and the program take effect the following year. Under this model, Year One serves as an important opportunity for baseline data collection.
- **Consistency.** Performance measures should apply across all MCOs with consistent targets, assuming all MCOs are statewide and serve all SoonerCare populations.
- **Options for Attainability.** Provide multiple opportunities for MCOs to attain goals, such as meeting target, year-over-year improvement, high performer credit, or movement to next NCQA benchmark percentile.
- **Target Setting.** Establish targets based on historical performance data in Oklahoma so targets are both realistic and attainable. Since historical data may be limited as the State transitions to managed care, and COVID-19 has disrupted the 2020 measurement year, we suggest that OHCA collaborate with MCOs in the first several years of operation to select fair targets and execute an annual verification/adjustment process.
- **Continuity.** Keep measure specifications aligned to NCQA's annual updates, if applicable, and avoid adding or removing measures for three years, unless a measure is retired from HEDIS altogether.

While not typically part of an MCO incentive program, we recognize the value of MCO Performance Improvement Projects (PIPs) in making targeted improvements to aspects of the managed care program. There are multiple approaches to the selection and design of PIPs, from collaborative PIPs where MCOs work together on the design to full MCO flexibility in topic selection and design. The options provide varying levels of consistency and flexibility, both for providers and MCOs. As Oklahoma Medicaid transitions from FFS to managed care, we recommend that OHCA select performance improvement topics that align with State health priorities and give MCOs the flexibility to design and implement the PIP using their experience with different strategies and methods for improving member outcomes. In general, we recommend that OHCA require no more than three PIPs with a total length of three years each. Limiting the number allows the MCO to focus effort on improvement and a three-year duration provides sufficient time to evaluate results, make necessary adjustments, and demonstrate lasting improvement.

As we discuss in our response to the Benefits Provided through MCOs section, we recommend that OHCA include a member incentive program as a core program requirement. Although this is not a direct MCO incentive, the existence of a contract requirement to operate a member incentive program will further align MCOs' efforts to drive progress in the measures that OCHA selects.

Most Important Indicators of MCO Performance

- *What are the most important indicators of MCO performance? Why?*

There are multiple ways to evaluate MCO performance, and many indicators are quantitative and easy to measure and evaluate. OHCA should also consider more qualitative indicators, such as collaboration with the State and other MCOs and flexibility and adaptability to changing requirements and situations. For example, some of our affiliates regularly engage an independent organization to gather feedback from their state partner to, among other things, make sure they are actively listening to concerns and addressing needs. While more difficult to measure, these are also important gauges of an MCO's ability to create a long-standing partnership with the State in support of the Oklahoma Medicaid program.

Amerigroup believes the most important quantitative indicators of MCO performance are:

- NCQA Accreditation
- Standardized Quality Measures of Health and Member Satisfaction
- Operational Metrics
- Provider Satisfaction
- Financial Stability

In the following sections, we provide information on why each of these are important indicators of MCO performance, along with some specific examples. We discuss some of these topics in more detail elsewhere in our response to this RFI.

NCQA Accreditation

We support OHCA's decision to require MCOs to achieve NCQA Health Plan Accreditation because it demonstrates a commitment to quality and provides an even playing field across MCOs in the areas of quality and accountability. NCQA Health Plan Accreditation emphasizes performance through a rigorous review of a health plan's structure, processes, and records, in addition to standardized HEDIS and CAHPS® measures. In addition, OHCA should give preference to MCOs who have demonstrated the ability to attain additional recognitions from NCQA, including the Multicultural Health Care Distinction that recognizes an MCO's efforts to address the diverse needs and experiences of members and efforts to improve Culturally and Linguistically Appropriate Services.

Standardized Quality Measures of Health and Member Satisfaction

One of the most important indicators of MCO performance is impact to member health outcomes as evaluated using standard clinical quality measures, such as NCQA's HEDIS measure set. HEDIS measures are an integral part of MCO quality management and improvement and are already a part of how OHCA measures quality in the current SoonerCare program. NCQA regularly updates the measures to reflect new medical evidence and emerging trends in care patterns, including the current surge in virtual visits due to COVID-19.

To understand member satisfaction, we recommend annual measurement via the CAHPS survey instrument. Separate versions of the tool exist for Adult and Child members and Amerigroup affiliates routinely use both in Medicaid health plans. A third set of potential indicators that OHCA may consider are the Child and Adult Core Sets of Measures for Medicaid and CHIP, maintained by CMS.

When drawn from one of these reputable sources, MCOs, providers, and other stakeholders can have a high level of confidence that the measures are methodologically sound. Additionally, the consistency in data collection and calculation provided by standardized measures will allow OHCA to evaluate all MCOs efficiently and fairly. We discourage OHCA from designing Oklahoma-specific quality indicators for MCOs that have not been tested and validated elsewhere, as this could add significant reporting burden for MCOs and providers. Due to their prevalent use across Medicaid managed care, MCOs should have experience in using standardized measures of various types to improve health outcomes.

Operational Metrics

The ability to consistently meet operational requirements is a key indicator of overall MCO performance. Operational excellence in areas like enrollment, claims, call center, and report submission provide the foundation for the MCO's clinical model and can positively affect member and provider satisfaction with managed care operations. Within MCO operations, we recommend that OHCA focus on these key indicators:

- **Enrollment — 24-hour Load Percentage.** MCOs need to process and load enrollment files from the State quickly and accurately and assign members a PCP so they can begin to access services.
- **Claims — Timely and Accurate Payment.** Timely and accurate claims payment is a key driver of provider satisfaction, and access to a complete set of claims data helps MCOs identify members for clinical programs and supports care management and care coordination activities.
- **Call Center — Customer Satisfaction.** Calls to Member Services and Provider Services Helplines and the BH crisis line need to be answered promptly in order to be responsive to caller needs. This can be measured by the percentage of calls answered within 30 seconds.
- **Report Submission — Timeliness and Accuracy.** OHCA needs timely and accurate reports from MCOs in order to administer and monitor the managed care program. MCOs should be held to a high performance level in submission of regulatory and ad hoc reports.

Provider Satisfaction

A high level of provider satisfaction helps MCOs maintain a provider network that can meet the health care needs of SoonerCare members across the state. Annual provider satisfaction surveys of a random sample of the MCOs network provide an objective, systematic review of activities and systems to assess quality of care and services against standards and help identify areas for service enhancement. Amerigroup recommends that MCOs assess provider satisfaction in a number of areas, such as:

- Education and training
- Communication and technology
- Claims processing and provider reimbursement
- Continuity and coordination of care
- Utilization management and chronic care management
- Provider complaints resolution

Financial Stability

OHCA needs MCOs that have demonstrated financial strength and stability. A strong starting financial position can provide OHCA with the assurance that the MCO can withstand the

financial stress of early years of operation. We recommend that OHCA consider three indicators of MCO financial strength:

- **Administrative Efficiency.** MCOs need efficient administrative operations and strong administrative cost controls to sustain fluctuations in medical loss ratio without detrimental impact to financial stability.
- **Liquidity.** The liquidity of the balance sheet is important and a ratio of at least 1:1 indicates the ability of the MCO to pay its current debt.
- **Solvency/Net Worth.** Solvency/net worth adequacy in the form of a risk-based capital (RBC) ratio beyond 200% of authorized control level RBC represents strength in the MCO's financial performance and parental backing.

What Measures of Health Outcomes Should Be Tracked

- *What measures of health outcomes should be tracked?*

As discussed in our response to earlier questions in this section, Amerigroup recommends that the State track health outcomes using standardized measures, such as HEDIS. Use of HEDIS measures is already in place in Oklahoma, and has the additional benefit of aligning with NCQA accreditation requirements for MCOs. HEDIS provides a comprehensive set of measures with defined calculation guidance (numerator, denominator, exclusions) that will promote consistency across MCOs. HEDIS measures health care performance on processes, outcomes, and utilization, and helps identify improvements that can make a meaningful difference in the health and well-being of SoonerCare members.

At a minimum, MCOs should track measures related to State health goals such as healthy pregnancies, opioid use, childhood wellness, BH, diabetes, and cardiovascular disease. The HEDIS measures we list in Table 1 are among those we recommend OHCA track based on our knowledge of local health needs and review of the most recent "Quality of Care in the SoonerCare Program" report.

Table 1. Recommended HEDIS Measures to Track Health Outcomes

Recommended HEDIS Measure	Rationale
Childhood Immunization Status (CIS)	More than half of SoonerCare members under two years old are missing at least one immunization. Oklahoma's rate for several early childhood vaccinations lags the national average by a factor of two or more.
Controlling High Blood Pressure (CBP)	The category of Health Disease Deaths in the Oklahoma State of the State's Health Report has consistently earned an "F" grade since 2000. SFY 2019 data show 9.4% of SoonerCare members have hypertension (94,082 members).
Comprehensive Diabetes Care (CDC)	The HEDIS 2017 compliance rate for HbA1c testing was 74.2% in SoonerCare versus 87.6% nationally. Differences in Diabetic Retinal Eye Exams and Nephropathy Screening are even more dramatic, with a spread of more than 25 percentage points on each measure.
Risk of Continued Opioid Use (COU)	On the related measure of Use of Opioids at High Dosage, performance in Oklahoma decreased between 2016 and 2017. In 2018, an estimated 43% of drug overdose deaths in Oklahoma involved opioids, totaling more than 308 fatalities.

Recommended HEDIS Measure	Rationale
Flu Vaccinations for Adults (FVA)	The Centers for Disease Control data indicates that only 51.3% of people in Oklahoma received a flu shot in the 2108-2019 flu season, and compliance rates may be even lower among SoonerCare members.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The number of adults in SoonerCare with at least one ambulatory or preventive care visit decreased from 2016 to 2017, and shows significant opportunity for improvement in the 20–44 age range.
Prenatal and Postpartum Care (PPC)	SoonerCare paid for 57% of Oklahoma's births in SFY 2019. In 2017, 30% of pregnant women in SoonerCare did not receive timely prenatal care and 31.9% did not receive a postpartum visit.
Well-Child Visits in the First 30 Months of Life (W30)	This is a new HEDIS measure. Oklahoma's most recent EPSDT Participation Ratio for Age 1–2 was .73, short of the .80 encouraged by CMS. About 66% of children in SoonerCare completed six check-ups before reaching 15 months of age, compared to more than 96% nationally.
Child and Adolescent Well-Care Visits (WCV)	This is also a new HEDIS measure. Children and adolescents account for the bulk of SoonerCare members (more than 620,000 in SFY 2019) and preventive care is vital to maintaining health throughout their lifetime.

Additionally, the State needs an MCO that can demonstrate experience with measure stratification that can shed light on areas for improvement in health disparities. We also recommend that OHCA collaborate with the State public health department to obtain any additional population-level indicators needed to complement data provided by MCOs.

Impact of the COVID-19 Pandemic on Health Outcome Measures

COVID-19 has had a significant impact on the health care delivery system, with many preventive care and other non-emergency appointments being delayed. The country is experiencing an unprecedented decrease in routine check-ups, immunizations, cancer screenings, and other types of preventive care; these trends are revealed in quality measures.

NCQA and CMS continue to provide updates on MCO reporting requirements, and suggest that current contract requirements around MCO performance incentives may need to be re-visited if they require attainment of specific rates for HEDIS measures. Professional societies, including the American Academy of Pediatrics and American Academy of Family Physicians are also making recommendations related to macro-level trends in vaccinations, pivoting to virtual care delivery, and safely reopening practices for face-to-face visits.

We recommend that OHCA select MCOs who can partner closely with the State and jointly navigate the impact of COVID-19 and the health outcomes of SoonerCare members, addressing methods to identify and close gaps and maximize member well-being.

Care Management and Coordination

Promoting Effective Utilization Management Tools

- *How can utilization management tools work best for members and providers?*

Utilization management (UM) helps improve health care quality and outcomes, promotes consistency in clinical decision-making, and reduces costs as well as the incidence of medically unnecessary, duplicative, or ineffective care. UM tools are helpful in synchronizing the delivery of health care services across providers, so that members receive fully coordinated care as well as safe discharge planning and care transitions.

UM tools work best as part of an integrated approach designed to address members' PH, BH, and SDOH needs — from helping them access wellness and prevention services to assisting those who have chronic conditions or complex health needs. We support using evidenced-based practice guidelines and clinical decision support tools as part of UM, and bringing together the best technology, data analytics, processes, and staff so that members receive the highest quality of care in the most appropriate setting.

Easy-to-Understand and Easy-to-Navigate UM Tools

UM programs should include a broad array of tools and resources along with best practice clinical guidelines, UM review processes, and targeted outreach and education. Further, we recommend UM processes that are transparent and easy-to-understand for providers and members, with training and alerts offered to providers on UM process changes. For instance, OHCA should look for MCOs who offer training to providers on UM processes and who can offer easy-to-use and accessible resources and request forms, such as an online portal for requesting authorizations and submitting clinical information. OHCA may also consider working with MCOs for alignment with regards to prior authorization requests and submissions, such as a uniform prior authorization request form. MCOs should also follow mental health parity guidelines and have policies and procedures in place to help assure compliance.

In addition, we recommend UM tools that incorporate the following to best serve members and providers:

- A full picture of the member (including history, lab results, missed services, and more) to assist providers and the MCO in the UM process and to provide insight into a member's potential future risks as part of prior authorization requests
- Nationally recognized evidence-based guidelines that are readily available to members and providers, and that assure consistency and fairness in UM decision-making so that members receive the most appropriate level of care
- Continuous data and reporting that enable MCOs to identify opportunities for improvement in UM processes and tools
- A broad array of accessible, on-demand resources and service request forms, manuals, and resources that members can easily access and use
- Clear, easy-to-understand information, such as notifications of determinations and our grievances and appeals process as well as members' rights and responsibilities

Encouraging Consistency Across MCOs in the UM Process

- *How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?*

Amerigroup supports consistency in UM across MCOs to reduce the administrative burden on providers. We recommend OHCA collaborate with MCOs to adopt universally accepted medical necessity criteria as well as streamline the provider experience with the UM process wherever possible (for example, requiring MCOs to maintain online and telephone-based submission options and creating standardized prior authorization forms and trainings). We also suggest that OHCA allow MCOs the flexibility to leverage their resources and capabilities, such as automated systems, to minimize administrative burdens for providers. For example, in Washington, our affiliate worked with the Washington State Health Care Authority, providers, and the other Medicaid MCOs to identify opportunities for cross-system adoption of standardized processes. A result of this collaboration was an alignment of UM processes, including the standardization of prior authorization submission requirements.

Supporting Providers and Reducing Administrative Burden

OHCA should select MCOs with experience in meeting standardized requirements (such as NCQA accreditation), providing enhanced oversight, and collaborating with other MCOs to incorporate standardized submissions, decision timeframes, and evidence-based standards. These capabilities will foster a culture of innovation that will better support providers and minimize administrative burdens. MCOs must be able to support providers to make sure they have the information and assistance needed, so they can focus on serving members without disrupting or delaying care. Making any submission requirements as convenient and easy as possible will minimize any disruption or delay in services. The submission process must be quick and logical, aligned with clinical decision support tools and recognized clinical practice guidelines. For example, providers should be allowed to submit prior authorization requests in whatever way is easiest for their office (such as electronic or via standard submission) and be able to easily check on the status of their submissions. MCOs must be able to assist providers — through resources, tools, and training — and to tailor this assistance based on a provider's level of technology and capabilities in terms of submissions. Providers should also have the ability to reach an MCO quickly and easily, so they can ask questions and get information in a timely manner.

We suggest OHCA require MCOs, as part of their RFP response, to describe their specific prior authorization and other UM decision-making protocols and how these will be streamlined to mitigate any burdens for providers.

Network Development, Care Delivery, and Care Coordination Approaches to Better Meet Members' BH Needs

- *What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?*

Members with BH needs are at risk of not receiving the care they need due to a lack of access to BH providers and poor coordination of care between PCPs and BH providers. MCOs can better meet the needs of members with BH needs by contracting with a robust and comprehensive BH provider

network, specifying requirements for PCP referrals to BH providers, requiring bilateral communications and record-sharing between PCPs and BH providers, mandating availability of telepsychiatry services by network psychiatrists, and facilitating electronic medical records (EMRs). MCOs must also have the functional resources to provide training and education both to employees and BH providers and to comply with federal mental health parity requirements for the delivery and management of services. Further, MCOs should be able to promote whole-person health by integrating care coordination activities, health screenings and assessments, and a health information system. We recommend OHCA consider MCOs that have experience with a care management and delivery model that supports the whole-person needs of members, promote delivery through a local system of care, and have localized care management, tools, and analytics that help Medicaid members achieve healthier outcomes.

Through this contract, OHCA has the opportunity to improve the care of members with BH needs by working with MCOs to expand and enhance BH provider networks and incentivize the adoption of care delivery and care coordination processes that advance the integration of PH and BH services. PH and BH providers should play a key role in the design and implementation of these efforts.

Care Delivery and Care Coordination Approaches

High-quality, integrated, coordinated care for members with BH needs depends not only on PCPs and BH providers communicating with one another on a timely basis, but also care management collaboration within the MCO. MCOs need information systems that provide access to the treatment plans, assessment results, and summary notes either provider develops for the member (subject to any required consent). Electronic exchange of information between PCPs and BH providers through integrated EMRs or HIE would significantly improve care for members with BH needs by reducing risks (such as medication errors or overprescribing), controlling over-assessment, and supporting a cross system of care planning activities. Access to real-time ADT data is critical for all providers contributing to care planning for members.

We recommend OHCA and the awarded MCOs work collaboratively with providers, PCPs, and specialty providers to develop processes for bilateral communication (including closed loop referrals) and data exchanges between provider entities. These processes, which OHCA should consider requiring MCOs to mandate in provider contracts, should include the following:

- When a PCP refers a member to a BH provider, the BH provider should respond within a certain period of time.
- The PCP should share relevant information about the member, such as hospitalizations and medications, with the BH provider at the time of referral.
- When a member self-refers to a BH provider, the BH provider should be obligated to notify the member's PCP, and the PCP should acknowledge receipt of the notification.
- To the extent permitted by the member's consent, the BH provider should share the member's assessment, treatment plan, and status updates with the member's PCP.
- The MCO should assist PCPs and BH providers with exchanging notifications and documents electronically in either the member's EMR or an independent HIE.

Network Development Approaches

We recommend OHCA require MCOs to maintain a comprehensive BH provider network that assures provider availability across the continuum of BH services. The continuum includes both traditional BH providers, such as psychiatrists, psychologists, Psychiatric Mental Health Advanced Practice Nurse Practitioners (PMH-APRN), inpatient psychiatric facilities, community-based providers such as community mental health centers, and non-traditional providers, such as licensed professional counselors, licensed marital and family therapists, peer specialists, and crisis services providers. Psychiatrists in an MCO's provider network should be required to offer telepsychiatry, an important service that improves access to mental health specialty care and reduces delays in care, particularly for patients in rural areas. OHCA may also want to consider requiring MCOs to contract with case or care management providers in the community and providing reimbursement for care coordination provider services.

Improving Management and Coordination for Members

- *How can MCOs improve the management and coordination for members with chronic or complex health conditions?*

To achieve the best outcomes, MCOs must bring experience providing care management and coordination initiatives that meet the unique needs of members, from wellness and prevention to specialized programs for those with chronic or complex health conditions. MCOs should have experience with a population health model that is tiered to address the care continuum — it should be both flexible and responsive to changes in a member's health condition and needs, such as increasing or decreasing intensity of complexity, to achieve the best outcomes.

In addition, data from the State's enrollment files will be important to maximize the management and coordination for members with complex or chronic conditions. Enrollment data will help MCOs proactively identify members with escalating or urgent needs or risks so that management and coordination can begin as early as possible. In addition, MCOs with the capacity for data sharing through an expanded HIE can promote information sharing, assessments, and care planning between all providers involved in a member's care for better management and coordination of their needs.

MCO Integrated Care Management Approach and Strategies

The status of a member's PH or BH risks and needs will fluctuate, as will their needs and goals. MCO Care Managers can help recognize when a member's risk level and needs change, and then adjust a member's risk level up or down based on changes in their symptoms, behavior, use of health care resources, or family situation as well as their screening and assessment results and upon referrals from their providers or family members. Tailored interventions along with specialized disease and care management programs will help support members who have more complex health needs or chronic conditions.

As part of the procurement process, we suggest that OHCA require MCOs to describe their approach to care management and population health, and demonstrate that they have well-designed strategies to identify and address the needs of members who have chronic or complex needs. To complement these strategies, MCOs must bring experience and skill in meeting

members where they are, in their communities where they live and work. Through a variety of engagement strategies, MCOs must work collaboratively with members and their caregivers, providers, and community organizations to make sure that members have access to information and resources so they can actively participate in their health care and to encourage members so they understand their role in self-management of chronic conditions.

Reducing Barriers to Care and Improving Coordination

- *What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?*

To minimize barriers to care and improve coordination for specialized populations, MCOs should take a fully integrated systems of care approach that is person-centered, trauma-informed, culturally sensitive, and supports a person's needs across the systems of care. This approach helps makes sure all members have access to the wide range of program services and supports that address their needs and preferences. We recommend that OHCA look for MCOs that use this approach, incorporating a broad array of services organized into a comprehensive network that promotes collaboration and coordination, identifies and addresses health disparities, and builds on Oklahoma's inherent strengths. In addition, MCOs can minimize silos across programs by encouraging cooperation among stakeholders (MCOs, providers, community organizations), bringing all services under a fully coordinated system that is seamless for the individual.

Tailored Programs and Strategies for Specialized Programs

Within specialized populations, there are varying levels of complexities that impact the array of services and supports needed. OHCA should also look for MCOs with demonstrated experience in:

- Navigating the unique systems of care associated with specialized populations
- Deploying person-centered, trauma-informed, and culturally sensitive approaches to care coordination
- Building and managing comprehensive provider networks
- Engaging members and stakeholders
- Supporting and managing the exchange of information between system of care partners to facilitate the appropriate delivery of services
- Coordinating and supporting health homes for members with complex needs

A person-centered approach involves changing perspectives from simply providing care to working in partnership with each member. This can be achieved through fostering an environment that promotes personal control for making the decisions that affect overall health and quality of life. MCOs must approach care coordination holistically, beginning with learning about the individual's personal goals, needs, and preferences — which enables the care team and the individual to work together to identify the full range of services that support the individual's health and well-being.

To better understand and respond to the challenges and barriers that these members face, MCOs must effectively engage with members, their families and communities, and other stakeholders within their systems of care. OHCA should require MCOs to demonstrate their experience and their

data and reporting capabilities to capture population-specific information so that interventions can be designed appropriately for the identified community, and can be deployed to support members proactively and in a trauma-informed and culturally sensitive manner.

MCOs should also have experience developing partnerships with providers and community-based organizations to provide and coordinate care for members and cross-train with them on social drivers of health, mental health conditions and substance use disorders, motivational interviewing techniques, cultural competencies, and trauma-informed care. As part of the procurement process, we recommend OHCA ask MCOs to describe their experience with care management programs and how these serve each population. We also suggest OHCA allow MCOs to propose their own distinctive and prospective care management models and features along with demonstrated outcomes.

Member Services

Measuring Performance Through Strategic Member Services Metrics

- *What metrics should be used to measure MCO performance with regards to member services?*

Oklahoma Medicaid members should have the ability to receive accurate, timely assistance through a comprehensive, personalized Member Services program. Amerigroup recommends fully integrated communications processes, Helpline technology, and a focus on improving the member experience.

Recommended Metrics and Targets for Member Services

We recommend the following measurements for Helplines and Member Services teams, which are based on CMS standard measurements:

- Average blocked call rate of less than or equal to ***1%***
- Percentage of calls answered within 30 seconds equal to or greater than ***80%***
- Average call abandonment rate of less than or equal to ***3%***
- Customer satisfaction, based on post-call surveys, equal to or greater than ***90%***
- Percentage of replies to secure emails within one business day equal to or greater than ***90%***
- Resolution of appeals within 30 days for standard requests, 72 hours for expedited requests
- Resolution of grievances within 30 days
- Online provider directories updated weekly
- Replies to member messages on after-hours voicemail no later than the next business day

Additionally, we recommend MCOs offer Nurse Lines and BH crisis lines to handle urgent clinical matters, with 24/7 availability.

Amerigroup discourages OHCA from establishing any Helpline measure based on first call resolution, as it is an imprecise measurement. We also recommend that no measures require 100% compliance. A measurement at that level could foster rigid decision-making and unintended consequences of requirements contrary to the goal of helping members receive quality care.

Measuring Performance through Similarly Scoped Experience

Amerigroup recommends that the State require MCOs to demonstrate their capabilities through examples of implementations of a similar scope and size — specifically, their most recent Medicaid FFS to managed care migrations.

Addressing Member Language and Health Literacy Challenges

How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

Amerigroup recommends that the State require MCOs to develop and implement processes that facilitate members' understanding of their benefits and services. MCOs should use demographic data, State feedback, and engagement activities to identify language needs in the communities served.

All MCOs should provide member materials in the prevalent non-English languages — specifically for Oklahoma, in Spanish, Vietnamese, and Chinese. They should also make certain that all written materials for members are easily understood by individuals of varying literacy levels.

Language and health literacy support, whether oral, print, digital, video, or audio, should be consistent and transferrable between formats without a loss in quality or messaging.

We also recommend that the State request that MCOs demonstrate experience and/or well-developed strategies for providing language and health literacy support for AI/AN populations. As the state with the second largest AI/AN population, Oklahoma's MCOs should be prepared to address their unique needs while encouraging engagement and mitigating health disparities.

Translation Services to Facilitate Non-English Member Communications

MCOs should offer oral translation services for all of their Member Services Helplines to support translation for most languages, at no cost to members. The availability of these services should be clearly displayed in MCOs' member handbooks and on member websites.

MCOs must appropriately train Member Services staff to assess the language needs of callers and utilize translation services during calls. Amerigroup understands how crucial the relationships between members and providers are to overall health outcomes. Therefore, we recommend MCOs provide members with the ability to choose a provider that speaks their preferred language, and that an interpreter is available by phone or another medium to support members during provider visits.

We also recommend that OHCA work with MCOs that have experience performing vendor oversight on translation services vendors, including monitoring complaints and grievances.

Improving Health Literacy to Improve Health Outcomes

Gaps in health literacy affect members across race, ethnicity, age, class, gender, income, education, and health conditions. It is important that MCOs provide members with the supports needed to understand health information, enabling them to make informed decisions about their care. Members who struggle with basic literacy are likely to have gaps in health literacy as well. According to the Literacy Resource Office of Oklahoma Department of Libraries, in a 2013

study, 31% of adults in Oklahoma functioned at a basic literacy level, and 12% were below basic literacy[5]. The study points out that "adults that are below basic and basic literacy levels may have difficulty signing forms, locating information in text, calculating the total cost on an order form, and reading and understanding medicine labels, dosages, and warnings."

Amerigroup recommends that MCOs demonstrate a commitment to addressing literacy-based barriers through a comprehensive strategy that aligns with industry best practices and provides additional consideration for special populations.

The expectations for a solid health literacy strategy should include:

- Member-facing employee and provider training, which should be:
  - Conducted routinely, with ongoing support available in print and online
  - Focused on identifying members struggling with health literacy and offering assistance with reading and understanding materials
  - Aligned with cultural competency standards
- Development and maintenance of appropriate print and online materials, which should be:
  - Available in English as well as the most common languages for the demographics served, including adaptations for the visually impaired (Braille, large-print, or audio formats)
  - Written at or below the fifth grade level, in plain language
  - Reviewed regularly for updates, clarity, and accuracy
- Health education for members, which should be:
  - Gathered from demographic assessments and feedback from stakeholders, such as OHCA, members, providers, and community partners
  - Available via internet, in person, video, print and with community organizations
    - Examples include health fairs, webinars, workshops, newsletters, and flyers
  - Tailored for special populations, including members who speak English as a second language, members with an intellectual or developmental disability, or members that have vision or hearing impairments
  - Inclusive of VAS for literacy support, such as GED programs
- Use of technology, which may include:
  - Video presentations to explain health terminology, benefits and services, and other issues important to members
  - Health apps, instant messaging, text messaging, and website resources

Using Technology to Support Member Engagement and Health Literacy

- *How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?*

Amerigroup is at the forefront of the development and implementation of digital platforms that offer a customized experience for members and keep them actively involved in their care. Our

[5] http://libraries.ok.gov/wp-content/uploads/Stat-Reasons-Illieracy-presentation.pdf

recommendations for the RFP aim to motivate MCOs to fully embrace technology to usher in a more accessible, seamless, member-specific engagement process.

Amerigroup recommends that MCOs demonstrate innovation and thought leadership in their approach to members' access to health plan services and information via smartphones, computers, and other web-enabled devices. Within their RFP responses, MCOs should clearly explain how their technology can best support their members. In concert with their technology, MCOs should provide adequate training for member-facing employees, providers, and community partners to assist members in using these platforms.

An Integrated, Customizable Platform for Member Support

Amerigroup recommends a comprehensive suite of member support tools that address health, wellness, and informational functions accessible over web and mobile devices. Tools for provider searches, claims reviews, fitness and wellness tracking, health plan information, and links to electronic health records would promote members' health literacy and self-directed care. Regardless of the type or number of offerings an MCO's platform features, it should be:

- User-friendly
- Scalable to evolve in sync with technology and user demand
- Tailored to member conditions and needs
- Able to collect data for the MCO for assessment, tracking, and reporting
- Accessible to all users, including those who may rely on assistive technology

Amerigroup acknowledges that technology-reliant solutions are limited for statewide use because of broadband and mobile access issues, particularly in rural areas. We strongly encourage the State to advance investment in infrastructure for mobile and internet access to provide a wider range of options available for improving the health and well-being of Oklahomans. In the interim, MCOs should be prepared to bridge these technological gaps by:

- Supporting partnerships for Wi-Fi hotspots and device donations
- Optimizing website and mobile applications to be less taxing on slower connections
- Sending concise communications that do not require large data downloads

Building Relationships to Bridge Communication Gaps for Members

How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

As an organization dedicated to promoting whole-person care and addressing SDOH, Amerigroup recognizes that it is the MCOs' responsibility to use any available means to disseminate timely information to members regarding their benefits and services. MCOs should have the ability to analyze the effectiveness of different communication outreach strategies. While we encourage the State to push for investments in improving access to technology in rural Oklahoma, MCOs should be prepared to use alternatives that promote engagement and are in line with language and cultural competency standards.

Community Organizations Are an Important Resource for Members and MCOs

MCOs should foster partnerships with community organizations for meaningful member engagement. These organizations — including churches, libraries, recreation, senior and

cultural centers, shelters, and food pantries — are invaluable for their insight into the needs of members. They may also serve as resources for internet access for members that lack consistent high-speed internet in their homes. MCOs should work with community organizations to serve as venues for outreach, health and wellness workshops or classes, information sessions, resources for emergency aid and information, and advisory groups.

Working with Providers and Pharmacies to Promote Engagement

Members trust their providers and pharmacies to provide accurate and supportive health information. Obtaining provider and pharmacy cooperation to keep members informed about important health plan information (such as enrollment, connecting with the MCO, benefits and services, or emergency assistance) would allow for another method of communication on which members could rely without the need for technology. This is particularly important in rural areas where a lack of mobile and internet access is more prevalent. We recommend that MCOs leverage their provider relations teams to keep providers well-informed, so that they are able to give timely information to members.

Disseminating Information through Alternative Media Sources

For members without reliable mobile and internet services, getting valuable information from their health plans can be challenging. We recommend that MCOs leverage other media to reach members, particularly those residing in rural areas. Radio, television, and print announcements for events, contact information, emergency services, and plan changes would help bridge communication gaps. It is important for MCOs to incorporate these options into their communication strategies to maximize their reach throughout the state.

Leveraging Relationships to Secure Mobile and Internet Resources for Members

We recommend MCOs collaborate with State agencies, internet and mobile service providers, technology companies, and community-based organizations to explore solutions for rural access issues. These options could include helping members obtain low-cost, data-enabled smartphones available through the federal Lifeline program, computers, and Wi-Fi hotspots.

To assess the needs of members accurately, we also recommend MCOs work with the State to acquire and maintain updated member data. In order to have a true representation of their populations and determine the most appropriate communication methods for engagement, MCOs need to be aware of changes to their membership and adapt accordingly.

Using Innovative and Varied Solutions for Acquiring Member Feedback

- *How can MCOs communicate with members and receive regular input and feedback on program improvements?*

Feedback from members provides necessary insights that drive MCOs' targets for continuous improvement. Amerigroup recommends a mix of in person, virtual, online, and offline methods for receiving feedback from members in order to hear as many member opinions as possible. Qualified MCOs should be able to detail within an RFP response their experience with a variety

of programs designed to solicit honest, constructive feedback from members. Table 2 highlights avenues MCOs can leverage to obtain quality feedback.

Table 2. Member Feedback Provides Valuable Insight into Service Quality

Methods	Details	Benefits
Transition Town Halls	▪ Hosted by OHCA, all selected MCOs would participate in an open forum to address concerns about privatized managed care prior to Go-Live ▪ Provider groups, patient advocates, and other stakeholders in the community could also participate	▪ A collaborative event would be better received and attended than separate efforts by each stakeholder ▪ MCOs get real-time feedback ▪ Areas of concern can be addressed before the start of the contract ▪ Having MCOs and OHCA together demonstrates a sense of cooperation that could alleviate member concerns
Member Advisory Committee	▪ Composed of a diverse cross-section of members ▪ Meet regularly (such as quarterly) ▪ Can be in person, virtual, or a hybrid ▪ Provide a formalized agenda of topics to discuss ▪ Representatives from multiple health plan departments should participate to answer questions and obtain suggestions (for example, Member Services, Care Coordination, Population Health)	▪ Multiple ways to attend increases member access and participation ▪ Obtain member feedback in real time and provide rapid solutions ▪ Informs the health plan's overall approach to quality improvement
Member Surveys	▪ CAHPS member experience survey annually ▪ Other ad hoc surveys can be online, printed and mailed, or by telephone ▪ Data should be assessed by the plan and any negative feedback should be transmitted to the appropriate teams for problem-solving	▪ By having a variety of methods, members with accessibility issues can still participate ▪ MCOs can limit feedback to specific questions that they feel will drive their programmatic improvements ▪ Can be randomized, sent to all members, or directed to a particular section of the membership
Social Media	▪ Social media pages, polls, and groups designed to have open dialogue on processes, concerns, and the member experience ▪ Requires regular monitoring and moderating	▪ Social media is free and available to anyone with internet access ▪ Members could communicate on social media with their mobile devices, computers, or tablets at any time
Pilot Programs	▪ Before rolling out a new program or initiative, an MCO can opt to test on a particular segment of the membership to ascertain its effectiveness, ease of use, and overall quality	▪ Generates cost savings for the State and MCO by testing a product or service before its wide release
Website Feedback	▪ Website buttons to enable a secure message regarding quality of services, questions, complaints, or other matters	▪ As an issue arises, members can click on the button and send immediate feedback if they wish ▪ Does not require a separate app ▪ Can be made anonymously if the member is uncomfortable reporting a problem or complaint

Tools and Resources to Help Members Search for Providers

- *What tools and resources would help members search for providers? What information should be provided?*

Amerigroup recognizes that a core competency of a positive member experience is the ability to access care in a timely manner. Finding a provider that meets a member's diverse needs is pivotal to addressing their health concerns and keeping them on a path towards wellness.

Provider Directories Are an Important Resource for Members' Decision-Making

We recommend every MCO provide both an electronic version of the provider directory, along with the ability to provide a hard copy by request. The online directory should be updated weekly at a minimum. During major health events, such as those following a widespread natural disaster or during an epidemic or pandemic, we recommend that the State require MCOs to update electronic directories daily, until advised by the State that the crisis has passed. Failing to maintain an updated directory, particularly during periods of health crises or natural disaster, could result in delays and/or barriers to care, along with severe member abrasion.

The electronic provider directory should be available as part of the MCO's mobile app, be accessible on the website regardless of the device used (computer, smartphone, tablet), and meet 508c accessibility standards. It must also be easy for members to use and intuitive enough to return results for plain language search terms (for example, a member searching for "heart" would see results for cardiologists). The electronic version should be searchable against parameters important to the member, which will vary depending on their priorities. Examples include name, gender, location, hours, networks accepted, telehealth, areas of focus, languages spoken, and affiliated hospitals.

For members who do not have access to an online directory, we recommend MCOs provide a printed version on demand, in the member's preferred language, within five business days of the request. We recommend that the MCO's Member Services team have access to the updated online directory and are trained to search for providers on the member's behalf, should the member be unable or unwilling to use either version of the directory on their own.

Both versions of the directory should also adhere to the same standards for all member materials in terms of readability and availability in alternate languages as appropriate for the service area's demographics.

Provider Payments and Services

Metrics to Measure MCO Provider Services Performance

- *What metrics should be used to measure MCO performance with regards to provider services?*

Measures of MCO provider services performance often overlap with those for operational performance. In our Quality and Accountability section response, we recommend the adoption of measures of MCO operational performance metrics for functions such as claims payment and processing (turnaround time and accuracy) and customer satisfaction with the Helpline (measured by the percentage of calls answered within 30 seconds). These operational

performance indicators are reliable measures of provider services performance, and we recommend them in response to this question as well.

Provider satisfaction surveys, which should be conducted annually, are also valuable in measuring provider services performance because they capture the opinions of the "customers" of an MCO's provider services — the providers themselves. Randomized surveys of a sample of an MCO's network providers provide an objective, systematic review of the MCO's activities and systems, including those for provider services. Amerigroup recommends that MCOs assess provider satisfaction in the following areas:

- Overall satisfaction
- Willingness to recommend the MCO to a patient or another provider
- Claims processing
- Provider training and education
- Communication and technology
- Continuity and coordination of care
- Cultural competency
- Language
- Provider complaints resolution

Minimum Levels of Provider Reimbursement

- *Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?*

We recommend OHCA establish a minimum level of reimbursement that MCOs may pay network providers and hospitals at no less than 100% of the Medicaid FFS rate for the service or bundle of services (as authorized under 42 CFR § 438.6(c)(1)(iii)(A)), with an exception for national vendors (for example, laboratories) to allow for national or multi-market volume-based contracting.

We also recommend a maximum level of reimbursement for out-of-network (OON) providers to incentivize them to enter into provider agreements with MCOs. MCOs are more likely to achieve better health outcomes for their members when they can require providers to comply with contractual requirements related to quality of care. We propose OHCA adopt the following policy: if an OON provider is unwilling to contract with an MCO after three good faith attempts, the MCO's maximum reimbursement for that provider shall be 90% of the Medicaid FFS rate.

Appropriate Measures for Timely Payment of Claims

- *What is appropriate for timely payment of claims?*

Timely and accurate payment of claims is a critical component of provider satisfaction and an important focus as OHCA moves from FFS to managed care.

To make sure that providers receive payment quickly, we believe an appropriate measure for timely payment of claims is 90% in 20 days and 99% in 60 days, defined as the difference between the date of receipt and the date of payment (claim in the door and payment out the door). These timelines will give MCOs adequate time to adjudicate claims while delivering needed cash flow to providers.

We discourage OHCA from establishing any claims payment timeliness measure of 100% because it could result in unintended consequences. Should OHCA decide to carve-in some of

the currently excluded populations, we recommend a more aggressive standard for timely payment of claims to providers such as nursing facilities to support cash flow needs.

To further support providers with timely payment of claims, we recommend that OHCA require MCOs to execute a minimum of two payment cycles (paper checks and electronic funds transfer) on a weekly basis.

We also recommend that OHCA consider additional measures for claims accuracy — both payment accuracy (a measure of the number of claims with no payment errors relative to the total number of claims audited) and financial accuracy (a measure of the dollars in error relative to all dollars paid in claims audited). Claims adjudication accuracy is vital to an MCO's role as a steward of State funds and another key component of provider satisfaction. We recommend measuring claims adjudication accuracy using an end-to-end audit (receipt to final disposition) of a random sample of claims, with a target of 95% for both payment and financial accuracy.

Standardization of Functions and Processes

- *What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?*

We recommend the State consider standardizing the following four functions and processes:

- OHCA-led provider education programs jointly developed by the MCOs and OHCA (see our discussion of joint provider education programs later in this section)
- Prior authorization forms
- Contracting with a Credentials Verification Organization (CVO) that would process credentialing data on behalf of all MCOs
- A standardized provider network application and single provider data repository

Provider Education Programs Created Jointly by MCOs and OHCA

We recommend OHCA lead annual provider education forums presented at centralized locations throughout the state or via webinars at which MCOs present on various topics and contribute to presentations that address cross-MCO issues. Joint provider education programs reduce the amount of time providers have to spend attending provider trainings and help assure uniform content on a topic available to all providers. Amerigroup's experience with similar education programs in other states, such as Indiana, Kentucky, and Tennessee, has been positive.

Standardized Prior Authorization Forms

Standardized prior authorization forms used by all MCOs streamline the prior authorization process for providers and reduce administrative burden. The content of these forms would be jointly created by MCOs in a process facilitated by the State. Examples of standardized prior authorization forms used in other states include:

- A universal prior authorization form for all health care services
- A prescription drug prior authorization form (with a separate section for opioids)

OHCA should require all MCOs to use the forms it approves.

Standardized Credentialing Process Administered by a Statewide CVO

We recommend OHCA implement a statewide CVO model and do so before the end of 2020 to ease the administrative burden for providers during the network build period prior to the program effective date. A CVO can simplify and streamline the credentialing experience for providers when more than one MCO is attempting to contract with them by serving as a central repository for credentialing data and eliminating the need for providers to submit the same credentialing information to multiple MCOs. Under the model we are proposing, the CVO would do only the primary source verification for credentialing and recredentialing; each MCO would make their own credentialing and recredentialing decisions. In addition, the CVO would be used by all payors, eliminating the need for providers to submit and update their data in more than one location if they contract with multiple payors.

We recommend a partnership with OHCA, a CVO, and awarded MCOs to help assure the provider community fully understands the new process and to facilitate a smooth implementation. Several of our affiliates currently work with state CVOs (for example, in Texas and Georgia) and were involved in the transition to a CVO model in those states. By forming a task force to develop a cohesive strategy that streamlines communications and outreach, OHCA and awarded MCOs will establish a transparent, timely framework to successfully move to managed care in Oklahoma.

Standardized Provider Application and Single Repository for Provider Data

We recommend OHCA standardize the provider application for network participation and all MCOs be required to adopt the format. In addition, the State should establish a system under which providers send updates to their demographic, ownership, and other data to a single repository managed by OHCA or a contractor such as a CVO. OHCA or a contractor would distribute the updates on a weekly basis via file feed to the MCOs for directory and system updating. This system would reduce the administrative burden on providers to send updates to multiple MCOs and would significantly improve the accuracy of MCO provider directories.

Barriers to Standardizing the Recommended Provider Functions and Processes

We are not aware of any barriers to joint OHCA-led provider education programs or standardized prior authorization forms. Amerigroup operates in multiple markets where both are currently in place and work well for both MCOs and providers. We do not envision any barrier to implementing a CVO for Medicaid providers in Oklahoma. Issues faced by other states in adopting a CVO have related mostly to provider comfort level and process changes transitioning from an MCO-run credentialing system to a CVO, which will not be a problem in Oklahoma as the move to managed care is novel. We also do not think Oklahoma would face any major obstacles in implementing a standardized provider application form and centralized provider information repository. States such as Maryland maintain the database for all provider information.

Communications to Providers About Updates to Plan Policies

- *How can MCOs best communicate to providers about updates and changes to plan policies?*

MCOs can best communicate updates and plan policy changes to providers by using multi-modal formats that accommodate the preferences of every type of provider, from a large

hospital system to a small rural PCP. Electronic communications to providers via email and website portal should be prioritized. Communication formats should include:

- Electronic communications such as email that alert the provider to a newly posted update on the provider website
- Fax blasts to those providers who select this method
- A robust, easily navigable provider website where providers can find information about the updates and policy changes, including webinars, on demand 24/7 through a query function
- Push communications from the provider portal
- Webinars and in-person education sessions that explore the material in greater depth and provide an opportunity for providers to ask questions
- In-person reinforcement at periodic provider town hall meetings and during provider relations representative visits to provider offices to review and sharing of programmatic changes and policy updates

We recommend OHCA take the lead on communicating changes in State policies that affect providers across all MCOs so the messaging is consistent. This will minimize repeat communications to the provider from multiple MCOs, promoting efficiency and preserving message integrity. MCOs can follow up OHCA communications with an explanation of how they are interpreting the policy.

Helping Providers Navigate Plan Administrative Requirements

- *How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?*

To help Oklahoma providers' transition to managed care and minimize disruption to their business operations and patient care, MCOs will need to implement a comprehensive and flexible communication and education plan. Provider education should incorporate multi-modality delivery training processes (including in person, online courses, tailored webinars, and written materials). MCOs should offer required, regional, population-specific, and culturally competent education.

Provider needs vary by type of provider, size of practice, and geographical location. To target support, MCOs should tailor service models to specific provider types, including tribal, BH, and rural providers. Additionally, MCOs should maintain call centers with dedicated service representatives, and include specialized call centers, such as a specific help desk for electronic data interchange, to quickly deliver targeted support.

As discussed in an earlier response in this section, standardized processes can help ease the administrative burden on providers. Standardized forms and provider education programs created and held jointly by MCOs and OHCA will allow providers that participate in the networks of multiple MCOs to receive complete information when attending one session. Tasks like obtaining prior authorizations, submitting claims, and resolving billing issues are critical administrative functions that providers execute frequently. This is an area where OHCA and MCOs can work together to make the transition as easy as possible for providers, allowing them to focus on caring for SoonerCare members.

In addition to joint education sessions to review these topics, Amerigroup recommends that MCOs work together to create provider "Quick Guides" that combine information from all SoonerCare MCOs into a single document, making it easier for administrative staff to find information they need. Additionally, required use of national claim denial codes, such as Claim Adjustment Reason Codes and Remittance Advice Codes, will drive administrative simplification by offering providers consistency as they work with multiple payers.

Supports MCO Provider Services Staff Can Offer to Network Providers

Beyond contracting and billing, MCO provider services staff can offer education and assistance to network providers in multiple areas, such as:

- Regular communication and outreach through written collaterals, website information, and high-touch contact with Provider Services Representatives
- Multi-model communication regarding policy updates and changes (as discussed in an earlier response in this section)
- Helping providers — physicians, facilities, and non-traditional providers — shift from volume-based care to patient-centered, value-based care that improves member access, promotes healthy lifestyles, and manages cost
- Dedicating resources to provide consultative services based on provider communication preferences
- Education support for provider adoption of electronic health records (EHR) and use of the State HIE

Preparing Providers to Participate in Shared Accountability Models

- *What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?*

Shared accountability models can be successful at improving quality and health outcomes if providers have the necessary infrastructure and capabilities, understand OHCA's and the MCO's expectations for performance under the programs, receive actionable feedback on their performance from the MCO, and have access to key information and documents from other providers treating their patients.

To help and prepare providers to successfully participate in shared accountability models, we recommend OHCA:

- Clearly and robustly communicate to providers its intention to transition to value-based accountability and care based on quality and outcomes so that MCOs and providers are all aligned in focusing on OHCA's goals and priorities
- Adopt the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Method (APM) framework, which is used throughout the managed care industry, as the basis for its VBP strategy for MCOs
- Define clear annual targets for MCOs to meet regarding provider participation and spending in APM programs and hold MCOs accountable for meeting those targets
- Establish expectations for MCOs and providers that align with OHCA's pay-for-performance measures and outcomes goals

- Allow MCOs the flexibility to develop specific APMs or methodologies aligned with State outcomes goals and to submit those APMs for approval prior to deploying them with providers
- Assemble an MCO committee to:
  - Develop standardized performance principles and measures that would apply to all MCO shared accountability models to reduce the administrative burden for providers
  - Develop joint provider education programs to train providers on the standardized performance principles and measures
  - Identify approaches to support and empower providers in acquiring the capabilities needed to participate in shared accountability models and that take into account different level of challenges faced by small, rural, and tribal providers compared with larger providers and those located in urban areas.
- Require MCOs to develop and implement protocols to assist providers with closing gaps in care, including:
  - Providing actionable quality data to providers that identifies their HEDIS gaps in care so they can improve health outcomes
  - When provider performance is not optimal, implementing a formal process to help the provider remediate any challenges
- Mandate MCOs:
  - Establish protocols under which BH and PH providers are required to communicate with one another about referrals and exchange documents such as summary notes, treatment plans, assessment results, and consents for disclosure of Protected Health Information (PHI) through either MCO care management tools or an HIE to achieve care integration and health care measures
  - Describe their experience in this area in their RFP response
- Select MCOs that have protocols to help providers close care gaps and better integrate care for members with BH needs

It is important to recognize the different level of challenges faced by small, rural, and tribal providers compared with larger providers and those located in urban areas. Providers not affiliated with large health care providers in Oklahoma City or Tulsa may be unlikely to have the infrastructure needed to successfully participate in advanced shared accountability models. In addition, small, rural, and tribal providers may have little or no experience with VBO programs or using population health data sharing tools to improve performance and will need assistance to understand them.

MCO Support for PCPs

- *How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?*

PCPs play a critical role in managing their patients' care and driving health care outcome improvements. MCOs are a key partner for PCPs and have valuable tools and expertise that can help PCPs be more effective in caring for their patients. MCOs should be expected to support PCPs not only in traditional ways (for example, training, coaching, and having a strong specialty network), but also by assisting PCPs with care integration and infrastructure development and

providing financial rewards for performance on quality measures. We recommend OHCA include questions in the RFP requesting that MCOs describe their strategy for robust PCP support and practice transformation and demonstrate their experience in this area with outcomes from other markets. MCOs' strategies should take into account PCPs' geographic location, infrastructure capabilities, and experience. MCOs should be evaluated on their commitment to do the following to support PCPs:

- Offer training that is designed specifically for PCPs (for example, on population health needs and issues, trauma-informed care, and adverse childhood experiences [ACEs]) in addition to the training offered to the entire provider network
- Support practice transformation by providing coaching by dedicated Provider Services Representatives on how to implement evidence-based protocols, interpret the population health data shared by the MCO, and close care gaps
- Establish a robust network of specialists to which PCPs can make referrals to facilitate timely access to specialty care
- For members with complex needs, assist PCPs with care integration by requiring closed loop communication in contracts with specialty providers and providing tools for sharing assessments and care plans
- Help with necessary infrastructure support by offering access to MCO care management tools and by recommending vendor solutions for EMRs and telemedicine platforms
- Offer financial incentives for performance on defined measures through value-based purchasing programs
- Provide SDOH screening tools and guidance on addressing patients' SDOH needs

Network Adequacy

Working with Providers to Meet Timely Access to Care Standards

- *How should MCOs work with providers to ensure timely access to care standards are met?*

Timely access to care standards protect members from delays in receiving the health care they need when they need it. MCOs should work with providers to fulfill their responsibility under 42 CFR § 438.206(c) to make sure that providers meet the State's timely access to care standards by:

- Including timely access standards in provider agreements
- Educating providers on those standards
- Monitoring provider compliance with the standards
- Following up with providers found to be out of compliance and taking corrective action as warranted
- Providing information to providers regarding gaps in care and incenting provider to proactively outreach to members to close gaps

We recommend OHCA request that MCOs describe their strategies in other markets for working with providers to meet timely access to care standards and include examples and outcomes of those strategies.

Reasonable Time and Distance Standards by Provider Type

- *What are reasonable time and distance standards in Oklahoma by provider type?*

Amerigroup recommends OHCA model its MCO time and distance standards on the CMS Medicare Advantage (MA) plan time and distance standards in 42 CFR § 422.116. These standards were published as a final rule on June 2, 2020 (85 Fed. Reg. 33796) and became effective August 3, 2020. The regulations establish:

- The time and distance standards for MA plans by provider type (40) and county type (five) (these are found in Table 3 to Paragraph (d)(2) in 42 CFR § 422.116(d)(2))

Table 3. We Recommend OHCA Follow the Newly Established CMS MA Plan Time and Distance Standards

CMS' Medicare Advantage Plan Maximum Time and Distance Standards
42 CFR & 422.116, Table 1 to paragraph (d)(1)

Provider Facility Type	Large Metro		Metro		Micro		Rural		CEAC	
	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, 08/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology-Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology-Radiation/Radiation Oncology	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery.	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services-intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Faculties	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

- A policy under which only a percentage of beneficiaries must have access to at least one provider/facility of each specialty type within the time and distance standards for a county type (at least 85% of the beneficiaries residing in micro or rural counties or counties with "extreme access consideration" and at least 90% of the beneficiaries residing in large metro and metro counties)
- A customization process under which CMS may adjust a time and distance standard in a particular situation
- A new telehealth credit that, for 12 specialty provider types, gives an MA plan a 10 percentage point credit towards the percentage of beneficiaries that must have access to the provider type within the time and distance standards for a county type

We recommend adoption of the CMS MA plan time and distance standards for the following reasons:

- With the exception of the telehealth credit, CMS has been applying these standards for a number of years to MA plans, and they appear to be reasonable
- CMS updates the standards annually to reflect changes in the health care landscape (for example, closure of a medical practice or hospital)
- The CMS standards include an exceptions process under which an exception to the time and distance values can be granted on a case by case basis if a shortage of providers makes it impossible for a plan to meet the standards
- The CMS time and distance standards cover a large number of provider types and are broken down by five different county designations, including one for regions that have extreme access considerations, a label that applies to much of Oklahoma outside of its cities and large towns
- Allowing time and distance standards to be met for less than 100% of the beneficiaries is consistent with how several other states' MCOs address the problem of extreme provider shortages

Additionally, in a state like Oklahoma where large expanses are sparsely populated and have very low concentrations of providers as well as long travel distances, telehealth has enabled providers to deliver more care to underserved populations and extends access beyond time and distance. Thus, a credit for telehealth makes sense in evaluating network adequacy. The telehealth credit reflects CMS' latest policy decision, after taking into account comments from stakeholders across the country, on how telehealth should impact network adequacy standards.

Recruiting More Providers to Participate in Medicaid

- *How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?*

We recommend OHCA require MCOs to provide details in their RFP responses of their provider recruitment strategies, including for Indian Health Care Providers, which are specific to the unique health care delivery challenges in Oklahoma. At the very least, MCOs should propose to do the following:

- Work in partnership with organizations such as community-based organizations, trade organizations, and universities to support growth in the workforce and residency programs

- Help educate providers on the value of participating in Medicaid managed care as a coordinated system of care that can assist providers in improving outcomes for their patients
- Adopt financial incentives such as OON reimbursement policies that make contracting with the MCO more attractive

MCO Support of Workforce Development

- *How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?*

We recommend OHCA create a health care provider workforce development task force with the awarded MCOs that meets on a regular basis and has responsibility for identifying and documenting short- and long-term strategies for increasing provider capacity, including for pediatric dentists, pediatric psychiatrists, PCPs, and BH providers. This task force would also be responsible for engaging key stakeholders such as universities, credentialing organizations, and funding entities to assess identified strategies and help implement those that are deemed effective. Where possible, MCOs should work collaboratively to identify the current and emergent needs of the population by partnering with various trade associations and agencies within the state. The Oklahoma health care workforce solution will "take a village."

In addition, MCOs should be encouraged to develop their own initiatives to grow the workforce both by bringing in new providers and empowering existing providers to continue to meet the needs of members, both current and emerging. In other states, MCOs have supported workforce development through scholarships, mobile care, mentoring, community health workers, and collaborative provider models such as Project ECHO® (Extension for Community Healthcare Outcomes) that reduce the need for in-person specialty consults and education.

Grievances and Appeals

Receiving Feedback and Being Accountable for Member Concerns

- *How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?*

MCOs must incorporate multiple methods into their operations — both proactively through outreach and reactively through the member grievance process — to be accountable for and committed to addressing feedback from members and other stakeholders.

Listening Sessions

We applaud the State for its efforts during 2018 and 2019 to engage stakeholders through statewide community listening sessions, and we recommend that these sessions continue as OHCA transitions to managed care, beginning prior to implementation and continuing throughout the first year.

To make sure that members, caregivers, providers, and other stakeholders are well-supported in the transition to Medicaid managed care, we recommend that OHCA convene a series of open forums and listening sessions to hear from members, advocates, and other stakeholders. In working with other states as they transition, our affiliates have found immense value in the

information gained from holding these types of sessions that bring the State, health systems, MCOs, and other stakeholders to the table to address systemic issues and create responsive program design.

Receiving and Analyzing Grievance Data

Listening to and promptly resolving member concerns is a critical part of managed care operations. OHCA should seek MCOs that not only resolve member grievances and appeals promptly, but use the information to identify enhancement opportunities and prevent future grievances. We recommend, as part of the RFP process, that OHCA require MCOs to demonstrate their experience with the following:

- Operating an effective grievance and appeal program that protects the rights and health of members
- Maintaining the systems, processes, and resources that support full compliance with State and federal requirements
- Incorporating a comprehensive education and awareness program to make sure members and providers are informed and fully understand their rights and the processes to follow
- Using simple, convenient, and flexible submission options (such as in person, email, fax, or through contacting Member Services)
- Tracking and trending grievance and appeal data by a variety of factors such as topic, sub-topic, and volume (for example, the rate per 1,000 members)

Advisory Committees

SoonerCare MCOs should create and maintain a robust member and community advisory structure to hear member feedback in real time and provide rapid solutions. This structure provides an opportunity for MCOs to receive feedback and inform the health plan's overall approach to quality improvement. Member advisory committees should be composed of a diverse cross-section of members and meet regularly, in person, virtually, or through a combination of modes. In the RFP, we recommend that OHCA ask MCOs to explain their strategy for advisory committees, including how they will maintain adequate representation of SoonerCare members, especially those from rural areas.

Surveys

Surveys are an important vehicle for proactively gathering member feedback. OHCA should look for MCOs with demonstrated experience executing a CAHPS survey and then using the data to take action on quality improvements and network education.

If OHCA wants to survey members about items that are not asked in a CAHPS survey, we recommend using a unified process rather than having each MCO field an ad hoc survey. MCOs can jointly fund use of a single vendor to conduct the survey. The survey process would be a collaboration between OHCA and the MCOs and include a representative sample of members (and possibly providers) across the state.

Using Appeals Data to Improve Utilization Management and Access

- *How can the state and MCOs use appeals data to improve utilization management and access?*

Appeals data, as well as all authorization data, provide the State and MCOs with valuable information about benefit design, access to care, and UM.

Similar to grievance data, MCOs should demonstrate their experience and ability to track, trend, and analyze appeals data by a number of factors, such as the outcome of the appeal, actions taken as a result (such as provider training), and whether a member requested a State Fair Hearing. MCOs should use appeals data to create a feedback loop, incorporating analysis of appeals data into their quality improvement and UM programs, and be able to provide detail in the upcoming RFP responses. OHCA should seek MCOs that are practiced in making adjustments to the entire prior authorization process, including the services requiring authorization and the criteria, in response to appeals data.

When looking at appeals, MCOs should review the data by a number of dimensions, including procedure, diagnosis, provider, geographic area, and decision maker. Data analysis should look at patterns and trends and include prior authorization requests that are “overturned” on appeal and those “upheld” on appeal, because both can identify opportunities for improvement.

Analysis of appeals that overturn the initial decision can indicate a need to streamline the prior authorization process or execute additional staff training. Conversely, review of appeals that uphold the initial decision can highlight the need for additional provider education on medical policy or clinical guidelines.

Analysis of Prior Authorization Decisions

In addition to review of appeals data, OHCA should seek MCOs who embed monitoring and analysis of authorization requests throughout the determination process, including both approved and adverse benefit determinations. An experienced MCO will not wait for decisions to be appealed to analyze data, patterns, and volume to better understand the needs of members.

Tracking and trending authorization requests can provide insight into member access to services, especially review of special situations, such as requests for OON providers or out-of-state services. Analysis may also identify opportunities to modify the authorization request process up front and reduce provider administrative burden. For example, our affiliates routinely examine UM data to remove prior authorization requirements or modify benefit limits for procedures that have low utilization and high approval rates (such as tonsillectomies and pacemakers). Review of denied authorizations, especially at the provider level, may indicate the need for targeted education and outreach.

Administrative Requirements

Methods to Streamline OHCA and MCO Data Sharing

- *How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?*

Accurate, timely, and secure data sharing between OHCA and MCOs and between MCOs and providers will be critical to managed care operations, and protecting patient privacy is an obligation that all parties must take very seriously.

OHCA needs MCOs with experience sharing data of multiple types (such as member enrollment, encounters, and continuity of care information) and the system flexibility and knowledge to adapt to SoonerCare's data exchange protocols and the diverse needs of providers.

Amerigroup is a strong proponent of HIEs and will actively participate in the State HIE. HIE participation brings a number of benefits, most notably improving the quality and safety of patient care by reducing redundancies and medication and medical errors. The State HIE is an important resource to streamline data sharing and one that all SoonerCare MCOs and providers should leverage to improve patient care. Recognizing that the HIE may not contain all information (such as health assessments) and that some Oklahomans may choose to opt out of the HIE, OHCA should seek MCOs with the technology to provide alternative methods for providers to access critical member health data. This data can include procedures, diagnoses, hospitalizations, prescriptions, and lab results.

In their RFP responses, OHCA should expect MCOs to demonstrate established policies and procedures to safeguard information and systems and have expertise regarding laws and regulations governing data exchange and PHI privacy and confidentiality, including HIPAA regulations, 42 CFR Part 2, and the HITECH Act.

For data sharing between the State and MCOs, streamlining data sharing while maintaining patient privacy requires four major components:

- Standard transaction formats
- Secure file transfer method
- Schedule that includes frequency and time of day
- Appropriate privacy and security controls

We recommend OHCA require use of the HIPAA-compliant ANSI X12 standard transaction types for information exchange. X12 is an industry standard used across all 24 Medicaid markets operated by our affiliates, as well as the State's Medicaid Management Information System vendor, DXC Technologies. While we understand that pharmacy initially will be carved out, MCO efforts around whole-person care would benefit from ongoing access to prescription data, and use of the standard NCPDP format is highly recommended.

OHCA and MCOs' use of a secure, encrypted file transfer method is critical to maintaining privacy and security of all information, including PHI. MCOs should be adept at working with a number of transfer methods, including secure file transfer protocol (SFTP) and virtual private network (VPN), and be able to use a method that works best for the State.

Maintaining a schedule of data transfers streamlines the process and allows the State and MCOs to share data on reliable schedule and build appropriate business processes to consume

the data. Schedules should include the frequency (such as daily, weekly, monthly) and the time of day (and a daily transfer could be multiple times a day). The data sharing process should include regular monitoring of status notifications, extract files, and error logs to verify that each job executes correctly and that the results are consistent with expected record counts and transaction formats.

OHCA should also expect MCOs to have an appropriate multi-level data privacy and security governance model with well-defined roles, responsibilities, and controls and include an annual testing component.

For data sharing between MCOs and providers, we recognize that data sharing barriers exist and no single solution will work for all providers. Data sharing should be bi-directional, with data flowing both ways between MCOs and providers. To streamline data sharing, MCOs should demonstrate the ability to deploy a variety of methods that will help providers improve care by eliminating redundant tests and procedures, support care coordination and transitions, and reduce administrative burden.

Data OHCA and MCOs Should Share to Support Managed Care Operations

In addition to enrollment data and any other available health insurance information, the primary data MCOs will need from the State (directly or through the State HIE) is historical claims information to support continuity of care and early identification of health or psychosocial risk factors for proactive outreach. MCOs use historical claims information, along with ongoing prescription data, to assign PCPs, proactively identify members for care management and care coordination, and identify wellness and prevention opportunities, such as gaps in care or upcoming screenings needed for PCPs to address with their patients.

For continuity of care, timely access to information about members currently engaged in care or receiving services, including open authorizations, is important to protect member safety and make the transition to managed care as seamless as possible. Additionally, members in current care management and care coordination programs would benefit if MCOs have access to existing assessments and care plans in order to continue the seamless delivery of services currently in place or planned; this would also prevent member and provider assessment and care planning “fatigue.” MCOs could also benefit from any screening results of SoonerCare members that address PH, BH, and SDOH factors.

On an ongoing basis, MCOs need access to the same continuity of care information — historical claims data, open authorizations, assessments, and care plans — for members transitioning into their MCO from another SoonerCare MCO. Based on experience in other markets, we suggest that OHCA and MCOs collaborate on the best method to accomplish this MCO-to-MCO data sharing to support timely and actionable information transfer, with documented electronic access and sharing protocols and response timeliness.

Data Sharing Between MCOs and Providers to Facilitate Patient Care

Sharing timely and relevant data with providers is an integral component of managed care operations and helps providers improve patient care by eliminating redundant tests and

procedures and support care coordination and transitions. To facilitate the care of SoonerCare members, MCOs and providers should share the following types of data:

- Panel information to support member outreach, engagement, and service
- Member utilization data (current and historical) to support continuity of care
- Gaps in care to encourage appropriate utilization of services
- Referrals for care coordination, patient gaps in care, and care management for members with chronic or emergent needs
- Assessments and care plans to engage providers on the interdisciplinary care team
- ADT information to facilitate safe transitions and discharges between settings and support post-discharge care follow-up and medication adherence

MCO access to timely provider data will also help support patient safety through monitoring receipt of services and the UM process and can reduce provider administrative burden. OHCA should seek MCOs with experienced care management protocols and care delivery system support tools to facilitate bi-directional data sharing with providers.

Barriers to Data Sharing and How They Can Be Overcome

- *What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?*

It is crucial that MCOs work with each other, providers, and the State to address barriers to data sharing (submission and receipt) that some providers may have. Some prevalent barriers include:

- **Resources and Understanding.** Small providers may have limited staff with time to devote to learning data sharing methods that differ between the OHCA, SoonerCare MCOs, and the State HIE, MyHealth Access Network.
- **Technology Adoption.** Not all providers use an EHR system to support their practice or are connected to the State HIE.
- **Integration with Practice Workflow.** Some providers may lack the experience to know how best to integrate available data into their practice workflow in a way that improves patient care and simplifies office administration.
- **Internet Access.** Some providers lack reliable access to high-speed internet.

Overcoming many of these barriers requires that MCOs support multiple data sharing options, such as paper, electronic, and online, allowing providers the flexibility to share data using a method that fits within the dynamics of their practice. MCOs need the experience to recognize there is no single solution that will work for all providers, and data sharing methods may differ by the type of data to be shared.

Resources and Understanding

MCOs can use education and high-touch individual support to help providers overcome some barriers. OHCA should require MCOs give providers multiple options for understanding how to share data with the MCO and how to get the most value from the data. For example, MCOs should offer provider education in multiple formats (such as in person, webinar, and video) and

supplement education with telephone options (such as the Provider Services Helpline) and in-person visits from Provider Relations Representatives.

Technology Adoption and Integration with Practice Workflow

SoonerCare MCOs should maintain programs to promote provider adoption of EHRs and encourage participation in the HIE, even if they do not use an EHR. MCOs should have resources they can deploy to help providers understand the benefits they can achieve through use of an EMR and the HIE (including the MyHealth Provider Portal) and how to integrate their use into their practice workflow.

If the provider is reluctant to use an EHR or participate in the State HIE, the MCO should have alternative ways to share data.

Internet Access

OHCA should seek MCOs with the experience and willingness to explore and find solutions for geographic locations in Oklahoma that lack reliable access to high-speed internet to support provider data sharing activities.

Member and Provider Fraud Identification, Prevention, and Detection

- *How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?*

MCOs can help identify, prevent, and detect member and provider fraud by maintaining a formal Anti-fraud Plan that details an integrated system of resources, activities, processes, and controls that span all parts of managed care operations. For example, claims pre-payment edits, medical record reviews, third-party liability, care management, and post-payment investigation processes and staff all contribute to the successful identification of potential fraud. The Anti-fraud Plan needs to meet State and federal laws and OHCA requirements, and be comprehensive, actionable, and reviewed and updated regularly to address and incorporate emerging trends, lessons learned, and best practices.

To effectively combat fraud, the MCO must build trusted relationships and work collaboratively with OCHA, the Medicaid Fraud Control Unit (MFCU), and local and federal law enforcement. OHCA should seek MCOs with proven experience building and fostering productive working relationships across the state. We are strong proponents of working collaboratively with other MCOs to share information about schemes, cases, and investigative results. The opportunity to share results and findings with others delivers better efficiencies and results to all MCOs and directly benefits the SoonerCare program.

In drafting the RFP, we recommend that the State ask MCOs to detail savings and recoveries achieved in other Medicaid markets against defined metrics, defined periods, and where applicable, using defined calculations. Potential metrics include savings achieved through cost avoidance (such as claims edits, provider pre-payment review, provider behavior change, and coordination of benefits) and recoveries achieved post-payment (such as investigations). Potential defined periods and calculations could include limiting numerators to Medicaid operations and denominators to average Medicaid membership in a given two calendar year

period. This would allow the State to evaluate and compare MCO results in a consistent manner and for applicable experience.

Identification of Member and Provider Fraud

Comprehensive education and awareness programs for employees, vendors, members, and providers are key to identifying fraud. Training and awareness needs to be frequent and multi-modal so they create and reinforce awareness on how to identify and report fraud, waste, and abuse. Provider education on proper billing practices is critical, along with a variety of educational programs to help change provider behavior when aberrant billing occurs and could simply be the result of confusion.

Combating fraud also includes encouraging individuals (members, providers, employees, vendors, and law enforcement officials) to report suspicions of fraud, waste, and abuse and providing multiple channels to make it as easy as possible — especially for those wishing to remain anonymous.

Methods of Fraud Prevention and Detection to Deploy

A successful MCO program employs a variety of tools and processes to make sure services delivered to eligible members, and payments to providers, are effective, efficient, and legitimate. We recommend that MCOs focus substantial efforts on proactive prevention. Stopping payments before they are made is more efficient and cost-effective than pursuing recovery of overpayments and recouping payments that stem from instances of fraud, waste, and abuse. This focus on prevention should also include identifying outlier provider billing or coding practices and working closely with providers to drive behavior change.

There are a number of processes that are critical to preventing fraud, waste, and abuse, including:

- Training employees, vendors, providers, and members
- Maintaining clear provider billing policies and rules and adjudicating claims accurately, including:
  - Clinical policy and coding edits (including tools such as ClaimsXten)
  - Coordination of benefits and third-party liability identification and processing
  - Pre-payment review using medical records
- Maintaining effective claims processor training and quality audit programs
- Confirming that credentialed providers have the necessary licensure and monitoring to make sure excluded providers are not credentialed or paid

Detecting fraud in the Medicaid program also involves a number of key processes, including:

- Promoting a culture of vigilance among all employees and public awareness of reporting mechanisms
- Using advanced analytics to identify membership errors, provider billing errors, and payment errors
- Maintaining a quality and compliance review program for providers
- Providing explanation of benefits to a random sample of members to verify receipt of services billed

MCOs need to be just as diligent in correction activities after fraud is alleged, suspected, or confirmed, including following OHCA and MFCU requirements for reporting, investigations, and actions after a credible allegation of fraud is determined. MCOs need to implement actions to change behaviors, such as education, pre-payment review, and record audits and promptly resolve over- and under-payments.

Requiring MCOs to Offer Health Plans on the Marketplace

- *Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?*

We do not recommend the State require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace. While we understand the goal of increasing competition in the exchange, attempting to do this by requiring Medicaid plans to participate could have the unintended consequence of reducing competition for SoonerCare MCOs.

Our organization is a strong advocate of the Affordable Care Act and an active participant in the health insurance marketplace in 14 states. However, we believe that all businesses, including health plans, must have the flexibility to decide when market conditions provide a sustainable path to provide affordable choices to consumers.

Additionally, OHCA and MCOs will devote substantial effort over the next several years to implement a seamless transition of SoonerCare to managed care and achieve the State's goals of improving health outcomes of Oklahomans, transforming payment and delivery system, improving member satisfaction, containing costs through better coordinating services, and increasing cost predictability to the State. This will require significant attention from all parties involved. Linking participation in the Oklahoma Health Insurance Marketplace to Medicaid managed care operations does not take into account the regulatory, operational, and policy differences that exist between exchanges and Medicaid. This has the potential to detract from SoonerCare operations and the members, providers, and other stakeholders we aim to serve together.

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

August 21, 2020

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Procurement@okhca.org
Requisition Number: 80720200002

RE: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (Requisition Number: 80720200002)

On behalf of America's Health Insurance Plans (AHIP)[1], I write to provide feedback in response to the Oklahoma Health Care Authority's (OHCA) request for feedback as part of the SoonerCare managed care program redesign. AHIP and our member health insurance providers appreciate the opportunity to provide our comments as the state shifts towards a planned comprehensive Medicaid managed care implementation. We firmly support the position that Medicaid managed care organizations (MCOs) can improve health outcomes, increase access to care, and increase system accountability in the Oklahoma Medicaid program (SoonerCare) to assist the state in achieving Top 10 health status.

AHIP commends the state for pursuing a comprehensive Medicaid managed care approach to achieve the following payment and delivery system reform goals:

- Improving health outcomes for Oklahomans
- Transforming payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume
- Improving member satisfaction
- Containing costs through better coordinating services
- Increasing cost predictability to the state

Medicaid MCOs are uniquely positioned to be strong partners with OHCA to achieve these goals by implementing innovative, value-based, and person-centered managed care strategies.

Medicaid managed care will improve health outcomes for Oklahomans.

Medicaid MCOs are strategically positioned in the health care delivery system to improve health outcomes through value-based care, quality improvement initiatives, and resource investments. Further, there is mounting evidence to support that managed care can and does improve value and outcomes in the Medicaid program. States have found that, by moving to managed care,

[1] AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Visit www.ahip.org for more information.

they can implement programs that improve outcomes, like care coordination and utilization management that are more difficult or impossible to deploy and monitor in a fragmented fee-for-service (FFS) environment.[2]

Numerous studies have shown that when states implement Medicaid managed care, they see direct improvements in health care outcomes. In South Carolina, adult Medicaid enrollees with diabetes whose care was managed by Medicaid MCOs were more likely to receive consistent monitoring and support for their condition. Additionally, 63 percent of adults covered by a Medicaid MCO monitored their blood sugar compared to only 33 percent of adults covered by FFS. Children in Georgia enrolled in Medicaid MCOs were more than twice as likely to have six or more well-child visits in the first 15 months of life.[3]

Managed care transforms the payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume.

Transforming payment and delivery systems away from payment based on volume towards value-based payment means shifting from FFS programs to managed care. In FFS programs providers are paid directly for individual services rendered to Medicaid enrollees. Unfortunately, evidence has shown that the FFS approach incentivizes quantity over quality; providers are financially incentivized to overuse care.[4] To compound the concern for overuse of care, many FFS programs provide no mechanism for coordinating services across providers, ensuring that services are appropriate and necessary, and measuring the quality of care that is provided. The common result of FFS program implementation in Medicaid is beneficiaries receiving too much care and little or no assistance in navigating across multiple providers to obtain the necessary care they actually need.[5]

By contrast, in Medicaid managed care arrangements, the state contracts with Medicaid MCOs to administer benefits, arrange and coordinate care and services, and pay providers. The state pays the Medicaid MCO a fixed per-person monthly amount, called a per capita or capitated payment, to provide benefits to each of the MCO's Medicaid enrollees.[6] Through this payment and delivery system MCOs are encouraged to keep beneficiaries healthy across the full spectrum of their care. MCO contracts with states typically extend over multiple years, which also encourages MCOs to think long-term about improving health status and consumer engagement in a more global, population-level manner.[7] One method MCOs use to accomplish this is through collaborating with the Medicaid provider community to move toward value-based purchasing (VBP), including: quality incentives, bundled payments, innovation payments, and shared risk arrangements. For example, Nebraska's contract requires Medicaid MCOs to

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[2] *Achieving State Medicaid Goals through Managed Care*. AHIP. October 2018.
[3] *PQO Update: Performance Measurement*, J Carson, MD; Georgia Department of Community Health. October 2012.
[4] *Balancing Cost And Quality In Fee-For-Service Versus Managed Care*. Eddy, David. Health Affairs. Volume 16, NO 3.
[5] *Medicaid and Managed Care*. AHIP. September 2019.
[6] Ibid. 2
[7] Ibid. 1.

execute VBP arrangements with at least 30 percent of their provider networks by the third year of the contract, and at least 50 percent by the fifth year.[8] Ohio provides a similar approach to ensure value-based payments systems are in place. Medicaid MCOs are required to ensure that at least 50 percent of the aggregate net payments to providers are value-based.[9]

Medicaid managed care improves member satisfaction.

Improved member satisfaction in Medicaid managed care is evident in health outcomes and beneficiary satisfaction data. States rely on MCOs to provide care coordination and management services, and quality management programs to improve patient outcomes. A 2015 study of Medicaid managed care provided clear evidence that care coordination by MCOs achieved reductions in hospitalizations, unnecessary emergency department visits, and prescribing errors.[10] States track MCO performance through quality measurement and reporting using standard measurement tools and Medicaid-specific benchmarks.

In addition to achieving cost savings and better outcomes, which clearly impacts member coverage perception, research demonstrates greater beneficiary satisfaction for managed care enrollees compared to Medicaid beneficiaries enrolled in FFS programs. One survey found that 85 percent of people enrolled in MCOs reported satisfaction with their benefits compared to 81 percent satisfaction for those enrolled in traditional FFS Medicaid.[11]

Containing costs through better coordinating services.

Care coordination is directly linked with providing the right care, at the right place, and at the right time. A hallmark of care coordination is the ability of MCOs to provide Medicaid enrollees assistance navigating providers and services and treating their needs in a person-centered approach. This is especially true for high-risk populations such as those with chronic conditions or multiple, complex health care needs. Because patients in these categories need complex care by multiple providers and in many health care settings, containing costs is a high priority next to care quality.[12]

Medicaid MCOs have sought to coordinate the care needs of patients with chronic conditions or multiple, complex health care needs by developing disease management programs. Disease management programs address many different conditions, including diabetes, pre-natal/post-natal health, asthma, congestive heart failure, children with special needs, and people with

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[8] *The Value of Medicaid Managed Care: Innovating in Medicaid*. AHIP. May 2020.
[9] Ohio Rev. Code Ann. § 5167.33 (West)
[10] Ibid. 2.
[11] Morning Consult, June 23-July 1, 2016. https://www.ahip.org/wp-content/uploads/2016/08/Medicaid-Poll-Topline_Final.pdf
[12] *White Paper: The Value of Medicaid Managed Care*. Shurgarman, Lisa R. Bern, Jaimie. Foster, Jessica. Health Management Associates. November 12, 2015.

multiple chronic conditions.[13] Studies have found these programs lead to better care for beneficiaries, such as children with asthma enrolled in Medicaid MCOs.[14]

Medicaid managed care increases cost predictability for states.

As Oklahoma works to lessen the fiscal and humanitarian impact of the COVID-19 crisis while simultaneously expanding the Medicaid population, budget predictability will be more important than ever. Medicaid MCOs can provide that needed budget predictability because managed care is a full-risk-based health care financing arrangement. The MCO receives a pre-determined capitated payment to finance all the state contracted Medicaid services and supports for each of its Medicaid enrollees. When the cost of an enrollee's care is higher than the capitated payment the MCO must cover the added expense without receiving any additional money from the state. This budget predictability has been a key driver of the widespread adoption of Medicaid managed care.[15]

MCOs stand ready to partner with Oklahoma to help the state achieve its payment and delivery system reform goals. Implementing managed care in the SoonerCare program will not only help the state achieve these goals but will also steer the state towards becoming a Top 10 health outcome leader in the country. MCOs will facilitate this outcome by partnering with Oklahoma to improve health outcomes through value-based care, quality improvement initiatives, and resource investments.

Thank you for the opportunity to provide feedback on the SoonerCare Comprehensive Managed Care Program. We look forward to future opportunities to support Oklahoma's health care initiatives. If you have additional questions, I can be reached at (202) 400-0928 or jkeepes@ahip.org.

Sincerely,

Joshua D Keepes, J.D.
Regional Director, State Affairs

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[13] *The Medicaid Program and Health Plans' Role in Improving Care for Beneficiaries: What You Need to Know*. AHIP. June 2016.

[14] For example, see Rhode Island Department of Human Services, Monitoring Quality and Access in RIte Care, October 2009 finding 96 percent of such children age 5-9 and 94 percent of children age 10-17 in Rhode Island Medicaid health plans had experienced the appropriate use of medications for the control of their asthma.

[15] Ibid. 2.

OKLAHOMA ALLIANCE ON AGING STRATEGY COMMITTEE
RECOMMENDATIONS FOR
OKLAHOMA'S SOONERCARE COMPREHENSIVE MANAGED CARE

August 17, 2020

Oklahoma Alliance on Aging Strategy Committee
PO Box 12008
Oklahoma City Oklahoma 73157

Oklahoma Health Care Authority
Procurement

Re: SoonerCare Comprehensive Managed Care
80720200002

To Whom it May Concern:

The Oklahoma Alliance on Aging appreciates the opportunity to comment on the anticipated request for proposals for SoonerCare Comprehensive Managed Care.

We strongly oppose the OHCA plan to contract with for-profit MCOs to serve the Medicaid population and would recommend the OHCA continue its current management of the program. If this plan does lead to contracts with for-profit MCOs, our position is the medical loss ratio should be a minimum of 88%.

ABD, HCBS, home health, and institutional long-term care populations should not be moved to a capitated managed care program. Any move to change the current program for the ABD population should only be considered when a minimum of two years of data reflect improved health outcomes for Members of the new MCO based program. Improved healthcare outcomes for persons aged 50-64 will have a significant impact on their health status later in life, including their future long-term care needs. Remember, 100 Oklahomans turn 65 every day.

Thank you for your consideration of our following input. If you have questions, please feel free to contact Esther Houser at (405) 760-2316 or Trish Emig at (405) 269-3945.

Sincerely,

Esther Houser and Trish Emig
Co-coordinators

OKLAHOMA ALLIANCE ON AGING STRATEGY COMMITTEE RECOMMENDATIONS FOR OKLAHOMA'S SOONERCARE COMPREHENSIVE MANAGED CARE

Category 1 (OHCA questions in *italics* with OAoA Strategy Committee Responses in normal type)

Managed Care Enrollees

- *How and when should OHCA transition ABD and other initially excluded individuals to managed care?*

    - Oklahoma's ABD population, especially the aged population, faces many complexities and challenges compounded by multiple chronic conditions. We insist that this highly vulnerable population be included **only after** at least two years of conclusive data which reflects positive outcomes. We strongly support the following:
        - A pilot program with initial voluntary enrollment, based on how well the general population is treated and where the MCO can effectively deliver services with exemplary performance measurements,
        - Test sites for rural and urban Members,
        - More than two-years' delay from initial contract with MCO, and a
        - Tiered phase-in approach with institutional and HCBS populations and exempted or phased-in last.
        - Transition for ABD should be planned with stakeholder input including State Council on Aging, Oklahoma Alliance on Aging, Oklahoma Silver Haired Legislature, Alzheimer's Association, Long-term Care Ombudsman Program, Area Agencies on Aging, as well as other consumer-oriented stakeholders,
        - Communication plans for OHCA and providers for onboarding of new enrollees prior to MCO enrollment, and a
        - Hybrid approach that includes managed care in urban areas with fee-for-services made available for rural Oklahoma providers and enrollees.

- *Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?*

    - MCOs must provide all services for all enrolled Members.

- *How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?*

    - We recommend at least annual in-person visits with social services and robust supportive case management with quarterly follow-up including an incentive approach to get people to buy-in to changing their behaviors.

- Less sophisticated language is needed when communicating with consumers.

Category 2

Benefits Provided through MCOs

- *What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?*

  - We wholeheartedly support the Health Care Authority's requirements for benefits provided through MCOs.
  - We recommend improved broadband, computer and telemedicine access, transportation, nurse line for immediate issues, frequently asked questions and other online resources, and provide medical measurement devices such as scales, blood pressure cuffs, etc.
  - Survey active participants on what would make access to services easier for them.

- *What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?*

  - Case managers are needed to help guide consumers through change from FFS to MCO services.
  - Provide a current, online, interactive, integrated resource directory that leads to referral management in a closed-loop centralized system, timely portability and access (especially when transferring from one MCO to another) in compliance with HIPAA and enforced by the OHCA.

- *How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education, and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?*

  - We recommend robust case management, information and assistance services using nationally certified staff, with at least one-year experience in local resources.
  - If ABD is integrated – additional qualification in local aging services resources should be included in case management qualifications.

- *How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?*

    - We recommend telemedicine access for behavioral health and partnering with community health centers across the state; refer to first answer in this category to address need for devices to connect to telehealth.

- *What types of value-added services would be most impactful for Members in terms of improving health outcomes, prevention, and Member satisfaction?*

    - Provide medical measurement devices such as scales, blood pressure cuffs, etc., and provide devices needed to connect to telemedicine.
    - Provide dental, hearing and vision services, preventive services such as annual wellness visits, health coaching, remote monitoring, glucose devices and adequate supplies, medication reminders, access to wellness centers, nutrition, and nutrition services.
    - Cover Electronic Visit Verification (EVV) costs to HCBS providers and provide tablets, such as iPads or similar devices.

- *How can MCOs improve access to transportation for Sooner Care Members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?*

    - Continue ride-sharing services such as Uber and Lyft, continue SoonerRide services, encourage coordination with ODOT and regional transportation planning organizations to expand transit options, supporting rural regional transportation systems.
    - Support public-private partnerships for transportation for older adults and persons with disabilities, such as the Independent Transportation Network of Central Oklahoma.
    - Use less sophisticated language when communicating with consumers.
    - Ensure that multilingual staff or translators are readily accessible.

Category 3

Quality and Accountability

- *What mechanisms should the state use to incentivize MCOs to improve Member outcomes?*

    - Withhold capitation payments until performance measure are achieved and incentivize MCOs when they exceed expectations, if paid solely by outcomes.

    - Have independent external review of outcomes.

- *What are the most important indicators of MCO performance? Why?*

    - Member satisfaction,
    - improved health status of each Member,
    - network stability/provider satisfaction,
    - improved overall health outcomes,
    - access to timely appointments,
    - case-load size,
    - number of providers in each specialty,
    - percentage of appointments kept, and
    - resolved Member grievances.
    - MCOs should be held accountable for the required reporting of HEDIS measurements.

    - Why? To be successful, these are the kinds of results MCOs must produce.

- *What measures of health outcomes should be tracked?*

    - We recommend tracking: medication documentation, reconciliation, and management; falls, Opioid dependence, hospital readmissions, ER visits, chronic disease identification and management, mortality, safety of care, patient experience, and effectiveness of care.

Category 4

Care Management and Coordination

- *How can utilization management tools work best for Members and providers?*
    - Utilize Member-centered management tools which are varied based on the population being served.
    - Track frequently occurring and duplicated procedures and track associated health outcomes. Assess the results and make appropriate changes with provider and Member input.
    - Offer provider and Member call centers and helplines.

- *How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?*
    - There should be a HIPAA compliant electronic health information exchange operated by the state or third party, stressing portability and accessibility.
    - The onboarding process should include provider education and training during the lengthy transition from FFS to MCO environment.

- The utilization management process must be simple and easily populated and navigated.

- *What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?*

  - Crisis management and emergency response protocols and teams should be established to reduce need for law enforcement officer intervention.

- *How can MCOs improve the management and coordination for Members with chronic or complex health conditions?*

  - Prevention is needed at earlier ages to reduce the development and impact of chronic conditions.
  - We recommend risk assessment stratification that separates out Members with multiple chronic conditions and integrated personalized care planning that includes physical, social, behavioral health with improved outcomes for each Member. (Baby boomers make up 15% of the population in 2020 and two-thirds are impacted by chronic disease. Chronic conditions account for 70% of our $3 trillion in national spending. Enhanced services for the under 65 population will be needed to significantly reduce the financial burden of their care in later life.)

- *What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN Members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?*

  - Increase transportation coordination, provide translators to address language and hearing barriers, cultural sensitivity training for providers, outreach to all populations, home visits, after-hours access with live response, access with live response to locally trained operators.
  - Use less sophisticated language when communicating with consumers.

Category 5

Member Services

- *What metrics should be used to measure MCO performance with regards to Member services?*

  - There must be uniform metrics for all MCOs that serve Oklahoma, to include:
    - Number of appeals,
    - Resolution of Appeals/Non-Resolution of Appeals,

- Member Services Phone Center metrics including access to live person response, time to access a live operator,
- Total time to resolve Member issues,
- Member Services Hotline,
- Independent appeals entity like the State currently has, which represents a consumer mediation process that would measure complaints and resolutions.

- *How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?*

  - Provide for translators throughout the Managed Care system that would include virtual health care access. Use less sophisticated language.
  - Ensure there are available providers in network who have experience working with specific non-English languages to serve Members.
  - Guarantee that care is provided with cultural sensitivity.

- *How can MCOs use technology (such as web-based applications and mobile phones) to help Members with their health care needs?*

  - Provide Members with the necessary technology. Maximize technology support for Members and network to provide fluid communications.
  - Provide Member-based education to support use of technology.

- *How can MCOs best communicate with Members who do not have a mobile phone, computer, or reliable internet service?*

  - Provide Members with the necessary technology. Maximize technology support for Members and network to provide fluid communications.
  - When technology is not an option, the MCO must be able to meet the needs of the Member.

- *How can MCOs communicate with Members and receive regular input and feedback on program improvements?*

  - Establish an advisory council made up of Members to provide regular input and feedback for program improvements.

- Establish a provider council to provide regular input and feedback for program improvements.
- Provide a telephone hot-line open 24/7 with live responders.

- *What tools and resources would help Members search for providers? What information should be provided?*

  - A plan must be in place for Member access to all provider resources.
  - MCOs should create an icon to use in all on-line information that provides connectivity to the resource directory and other health care information.
  - Provide links from enrollment page to allow Members to select providers from MCO website.
  - Consider libraries and senior centers as locations for access to information.
  - Provide a live operator who has access to updated provider directory and Member resources.

Category 6

Provider Payments and Services

- *Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?*

  - OHCA should require MCOs to pay SoonerCare providers no less than 93.63% of the Medicare Physician Fee Schedule, as set in 2019 by SB1044.
  - Continue to pay Federally Qualified Health Centers and Rural Health Centers using the Prospective Payment System.
  - Pay Indian Health providers at the encounter rate whether or not they are in the MCO network.

- *What is appropriate for timely payment of claims?*

  - OHCA has an excellent reputation for timely payment of SoonerCare claims, often paying within a week of submission. A payment range of 1 to 2 weeks after submission for most claims should be expected from the MCOs. Some claims may take longer, but payment should be received within 4 weeks at the longest.
  - There should be weekly reimbursement payments to providers; apply current reimbursement standard with all payments to be paid mindful of frequency and timeliness.

- *What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?*

    - All MCOs should maintain a level of reimbursement that correlates with Provider Costs (Cost Reports).
    - MCOs should perform annual audits on Cost Reports.
    - Provide a clearing house for Provider Services to ensure timely and accurate payments. The time it takes to resolve billing issues is important. Frequent system changes by MCOs can become a problem for providers.
    - Standardize the content of each Member's record across all providers.
    - The Member's record must be transferred within thirty days of changing a provider; require the former provider continue to deliver the Care Plan until the new provider is in place.
    - Standardize care components that must be in each Member's Care Plan; standardize the documentation process of the Care Plans; plans must be implemented within seven working days of receiving a new Member.
    - Standardize the Member Grievance Processes.
    - Standardize the process for providers to use if there is something in a Care Plan that the provider wishes to eliminate.
    - Make discharge summaries available within 48 hours of discharge.

- *How can MCOs best communicate to providers about updates and changes to plan policies?*
    - MCOs should use Provider Letters like those currently sent by OHCA as well as web-based information/updates.
    - In-person visits can help to establish a relationship.
    - Any changes or updates to plan policies must include opportunities for provider input; if policy change is needed. enough lead time must be granted for providers to have ample opportunity to implement the needed change.

- *How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?*

    - Use the current reimbursement standards regarding timely payments of claims.

- *What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?*

    - Shared accountability is the result of using value-based payment models. As providers strive to achieve high quality care which results in better health outcomes, contain costs, and receive high satisfaction ratings from their patients, providers should receive higher reimbursement from MCOs.

- *How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training, or coaching would be useful?*

    - Standardized systems must be available - complaints, billing, helplines.
    - MCOs must provide customer services across all lines to assist primary care providers in the transition and ongoing operation of the Managed Care Program.
    - Provide financial incentives for quality improvement and improved health outcomes with additional incentives for sustaining continuous quality improvement.
    - Supply primary care providers with resources to include education, training, and ongoing clinical expertise.
    - Provide for case consultation with other clinical specialists.

Category 7

Network Adequacy

- *How should MCOs work with providers to ensure timely access to care standards are met?*

    - MCOs should contract with any qualified and willing Medicaid providers for at least two years. Providers must be in good standing with their professional licensing board, CMS and OHCA.
    - A sufficient choice (at least three) of primary care providers is critical. New patients must have access to first appointment within 30 days for routine care. Offer incentive reimbursement for providers who meet or exceed standards for timeliness of appointment.
    - MCOs should contract with at least one essential community provider if available in their geographical area.
    - Encourage use of mobile health vans.
    - Make telemedicine available to patients with access. Identify local sites where telemedicine can be set up.

- *What are reasonable time and distance standards in Oklahoma by provider type?*

  - Primary care provider access must be within 10 miles for urban areas and 40 miles for rural areas. Multistate compacts may be used to meet this standard.
  - Specialist access should be within 20 miles for urban areas and within 60 miles for rural areas where feasible. If adequate providers cannot be accessed, Members should be permitted to return to fee for service providers.

- *How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?*

  - Offer sign-on bonuses and/or higher reimbursement rates to help recruit rural or difficult to recruit providers.
  - Expedite the credentialing process. Accept all qualified and willing providers.
  - Reimburse CEUs to recruit providers.
  - Support small practices with services provided by the MCO, such as a 24-hour nurse line and video/virtual-telemedicine capability.
  - Encourage partnerships with physician manpower programs and other loan forgiveness programs; work with the Oklahoma legislature to expand loan forgiveness programs.

- *How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?*

  - MCOs should work with medical training sites and hospitals to develop new providers through programs such as Project ECHO.
    - Project ECHO (Extension for Community Health Care Outcomes) is a collaborative model of medical education and care management that empowers clinicians in rural and underserved communities to provide specialty care to more people right where they live. Using technology, Project ECHO connects an interdisciplinary team at the OSU Center for Health Sciences with community providers to discuss treatment for chronic and complex medical conditions. Launched in 2003 by the University of New Mexico, Project ECHO operates more than 90 hubs worldwide covering more than 45 diseases and conditions. https://health.okstate.edu/echo/index.html

    .

  - Provide free continuing education opportunities.

Category 8

Grievances and Appeals

- *How can MCOs and the state receive feedback and be accountable for addressing Member concerns? Are there proactive approaches that should be explored?*

    - A third-party, independent entity should be responsible for grievances and appeals process.
    - An independent, managed-care, consumer advocacy program modeled after the federal long-term care ombudsman program is strongly recommended. Enabling legislation would be necessary to establish such a program.
    - MCOs and OHCA should have toll-free number access 24/7 with a real person to receive feedback and be held accountable for addressing Member concerns in compliance with the ADAAA.
    - Simple procedures and easy to understand forms must be used for grievance and appeals.
    - People should be able to access an appeals process via telephone, email, or other electronic means as well as in-person contact, in compliance with the ADAAA.
    - Less sophisticated language is needed when communicating with consumers.

- *How can the state and MCOs use appeals data to improve utilization management and access?*

    - Compare the number of grievances resolved upon first contact with how many grievances remain unresolved to the satisfaction of the Member within 30 days; how many are repeat grievances, and how many require multiple levels of appeal?

Category 9

Administrative Requirements

- *How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data do require?*

    - Follow HIPAA regulations regarding data sharing.

- *What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?*

    - The main barrier is different providers use different systems that do not "talk" to each other.
    - There is a fear if providers share data, they might be penalized. Shared data should be used only to improve outcomes.
    - Ensure that providers have better equipment and network capability.
    - Address technical training for providers, as transitions to new systems are a challenge. Provide technology and tech support for tech-challenged providers.

- *How can MCOs help identify Member and provider fraud? What methods of fraud prevention and detection should be deployed?*

    - Conduct audits.
    - Data review should include:
        - Provider affidavits to certify the accuracy of billing and data,
        - Review billing information for abuse and potential fraud,
        - Review data to ensure providers and Members are not fraudulently sharing identification numbers.

    - Publicly post whistleblower protection and adhere to CMS guidelines.

- *Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?*

    - No, the state should not require MCOs to offer non-Medicaid plans.

NOTE: The Oklahoma Alliance on Aging Strategy Committee workgroup for this response included:
Anne Davis, Ph.D, RN
Jean Kelsey, MSW
Ruth Tatyrek, LCSW
Germaine Odenheimer, MD, Professor Emeritus OU College of Medicine
Randle Lee
Annette Mays, Executive Director, OAHC and Secretary/Treasurer OK Alliance on Aging
Ken Jones, Executive Director, ASCOG and President, OK Alliance on Aging
Trish Emig
Esther Houser, MSSW

BlueCross BlueShield of Oklahoma

Oklahoma Health Care Authority (OHCA)
Procurement Services
4345 North Lincoln Boulevard
Oklahoma City, OK 73105

August 17, 2020

To whom it may concern:

Please find enclosed Blue Cross and Blue Shield of Oklahoma (BCBSOK) response to the SoonerCare Comprehensive Managed Care Program Request for Public Feedback (80720200002).

After 80 years of service in the state of Oklahoma, BCBSOK remains steadfast in our commitment to ensuring all Oklahomans receive high-quality health care through a model that works for Oklahoma, for our providers, for our communities, and for our neighbors. BCBSOK commends OHCA for its ongoing efforts to support the health of the SoonerCare population - and for continuing to evolve and innovate the delivery of health care services through the pursuit of this new care model. We greatly appreciate this opportunity to provide feedback on the SoonerCare comprehensive managed care program design. Should OHCA have any questions or wish to discuss any of the information provided in more detail, please feel free to reach out to Miguel Soto via email at Miguel_A_Soto@bcbsok.com or by phone at 405.316.7085.

Sincerely,

Stephania Grober
Vice President of Operations
Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design (80720200002)

Managed Care Enrollees

How and when should OHCA transition ABD and other initially excluded individuals to managed care?

The move to managed care is a significant shift from the current delivery system – for currently enrolled individuals, providers, community organizations, OHCA, and the MCOs selected to manage the program. The expansion of Medicaid in Oklahoma will also bring changes to the current health care ecosystem. Therefore, OHCA may want to consider a phased transition approach to managed care, for example:

- **Phase 1 – October 2021**: OHCA's anticipated implementation date for initial enrollees, including: children, parents, pregnant women, and adults ages 19-64 eligible through Medicaid expansion
- **Phase 2 – October 2023**: aged, blind, and disabled (ABD) adult population, including dual eligibles (excluding those on waivers and in long-term care facilities)
- **Phase 3 – 2024**: adults enrolled in the Home and Community-Based Services (HCBS) waivers and adults residing in long-term care facilities
- **Phase 4 – 2025**: children with complex needs and disabilities, children in foster care, individuals with intellectual disabilities, and individuals with serious mental illness

It should be a condition of the initial procurement and contract that all awarded MCOs are required to serve all populations statewide and will need to be prepared to demonstrate their readiness to do so prior to each transition phase.

For the initial implementation (Phase 1), OHCA, MCOs, providers, and advocacy groups will need to collaborate closely on communications and awareness campaigns to provide a smooth transition for enrollees. Additional communication and coordination will be necessary for the Medicaid expansion population with the expected the July 1, 2021 start date for coverage, October 2021 managed care program start date, and the November – December 2021 marketplace open enrollment period. OHCA may wish to transition the Medicaid expansion population to managed care organizations during the first quarter of 2022 to reduce potential enrollee confusion and better provide clear direction on timelines, eligibility requirements, and available coverage.

Many of the individuals who will be initially excluded from managed care have complex needs and additional benefits, such as long-term services and supports (LTSS). States with managed care programs have typically taken a multi-year approach to transitioning these populations into managed care to allow MCOs, providers, and key stakeholders adequate time to build relationships and processes to best serve enrollees. OHCA should strive to partner with MCOs who are already operating in Oklahoma today and have demonstrable experience partnering with LTSS providers to navigate the nuances of managed care. This will create a seamless experience for individuals with disabilities and complex conditions where a lack of coordination can have a significant impact on health outcomes.

During the subsequent transition phases, OHCA and awarded MCOs should work together with advocacy groups, LTSS providers, and community organizations to define transition plans and any unique care model considerations. As new populations are transitioned into managed care, MCO care models will require modification to adequately identify and address the needs of the more fragile populations. OHCA will also need to refine its model for monitoring, oversight to ensure continuity of care, and timely issue resolution. Prior to defining requirements for MCO care coordination staffing, OHCA may wish to conduct a labor study to ensure the availability of licensed and unlicensed staff to support the growing ABD population and to avoid duplication of services already available through providers and local organizations. OHCA should work with selected MCOs to develop an innovative model for providing effective, locally delivered care management programs to achieve performance and quality outcomes.

A phased transition approach also allows time for OHCA to accumulate the utilization experience data and build the infrastructure necessary to assess the cost effectiveness of the managed care model and support various processes, including rate setting for MCOs. States with existing managed care programs have found a phased transition provides the time necessary to work with their actuaries to refine models for reasonable risk adjustment reimbursement methodology.

For the Medicaid expansion population, in particular, data availability for the entirety of the membership will be limited initially. Other states have experienced pent-up demand for health services in the first two years of its Medicaid expansion managed care program. OHCA and MCOs will need sufficient time with this population to understand true needs and medical costs. OHCA should explore establishing a risk corridor for at least the first two years of the managed care program for the Medicaid expansion population (in addition to a budget-neutral risk adjustment methodology for all populations). A risk corridor would serve as a mechanism to protect the State's budget for the Medicaid expansion population and support the overall stability of the managed care program.

Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

From a conceptual perspective, requiring all selected MCO to be capable of enrolling all populations helps to limit potential confusion and administrative burden placed on Medicaid beneficiaries, providers, community organizations, as well as OHCA for its oversight and contract management obligations. Additionally, allowing for the "carve-out" of certain populations or services may lead to an unlevel playing field among MCOs and could lead to stability issues for the managed care program model overall.

Medicaid beneficiaries, their families, and their extended support systems often have complex and diverse needs and require support outside the scope of clinical care to lead healthy lives. Medicaid enrollees also often have co-occurring challenges and conditions and can span any combination of special populations –at the individual member level and especially when

considering the family / household unit. Ensuring all MCOs enroll all eligible populations would streamline the provision of these services and supports. This program model would also help to limit potential confusion and administrative burden placed on providers, community organizations, and OHCA for its oversight and contract management obligations. This would eliminate the need for duplicative services, such as multiple care coordinators, and help ensure that household needs are met in an efficient, coordinated manner. This would also allow MCOs to scale local initiatives and create innovative programming to serve population health needs across communities.

BCBSOK has a strong and proven track record of working in partnership with Oklahoma's Tribal Nations and the Indian health system and recognizes the unique characteristics of serving the American Indian population within Medicaid. Should OHCA, in consultation with Oklahoma's Tribal Nations, determine that special considerations be made for American Indians/Alaska Natives under the MCO program, BCBSOK would be committed to continued collaboration to ensure their health needs are met.

How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Many Medicaid MCOs have experience and various approaches to engage individuals in their health care and healthy behaviors. Oklahomans will receive the best outcomes from MCOs who have established partnerships with providers and local Oklahoma community-based organizations and are able to create a multi-prong approach in engaging individuals in their health care. OHCA should define the MCO performance standards using generally accepted measures such as NCQA HEDIS standards, but not necessarily prescribe how MCOs should engage members to achieve those outcomes. This will allow MCOs flexibility in their member engagement approaches, the ability to partner with providers through value-based care arrangements, and lead to more innovative, efficient programs.

Benefits Provided through MCOs

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Access to quality health care services is critically important for OHCA to achieve its goals for this comprehensive managed care program. MCOs should be required to have a statewide network that can adequately provide access to health care and meet the needs of SoonerCare enrollees. OHCA should require this as a condition of the procurement. MCOs should also be encouraged and allowed to be creative in their solutions to make it easier for individuals to access health care. MCOs, for example, could provide enhanced telemedicine and virtual visit options for individuals to access preventive services and care in the evenings and on weekends. OHCA should allow for MCOs to use a portion of their medical spend toward case-by-case services, such as the costs of traditionally non-covered benefits to address social determinants of health (SDoH) related needs.

What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Medicaid MCOs can deploy various strategies, technology, and platforms to facilitate the integration of behavioral and physical health services, shared assessments, and other data elements. As part of its procurement evaluation process, OHCA should include criteria requiring MCOs to demonstrate their experience in Oklahoma with employer, marketplace, and Medicare provider networks and their established integrations with MyHealth Access Network (Oklahoma's HIE). These established provider networks and data integration will be critical to improving integration of services for enrollees – particularly as SoonerCare enrollees move across various payer sources.

OHCA should also be mindful of potential requirements that will restrict the integration of services. For example, for care planning purposes, OHCA should not require a physical signature but instead allow enrollees to electronically sign their care plans and release of information to their selected integrated care team – i.e. physical health, behavioral health, community providers, family members, etc.

How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

The facilitation of referrals and outcomes tracking for social services, such as housing, food, education, and employment services will require significant coordination with Oklahoma's current community organizations and non-profits. MCOs with well-established, positive relationships with community organizations within Oklahoma will be best positioned to facilitate and track outcomes of social service referrals. OHCA should therefore include in its managed care procurement evaluation focused criteria requiring MCOs to demonstrate their ability to establish and utilize community relationships within Oklahoma. OHCA may wish to study North Carolina's implementation efforts[1] to better integrate and measure nonmedical drivers of health care. North Carolina and other states have shown that the facilitation of social referrals and outcomes measurement is possible to implement with MCOs, but will take significant time and effort to do so. Referral and outcome tracking processes will require a multi-year, phased approach to: establish baseline data and screenings to track SDoH needs, demonstrate various types of feedback mechanisms, and allow time for community organizations and non-profits to adapt to platforms or processes to truly meet the objective of measuring outcomes of referrals.

To avoid putting undue pressure and stress on community organizations – who operate on already limited budgets - OHCA should not mandate a statewide referral and tracking mechanism for awarded MCOs at the onset of the managed care contract. Instead, OHCA and awarded MCOs should work together to establish baseline processes. OHCA and MCOs could

[1] Buying Health For North Carolinians: Addressing Nonmedical Drivers Of Health At Scale 10.1377/hlthaff.2019.01583 HEALTH AFFAIRS 39, NO. 4 (2020): 649–654 ©2020 Project HOPE— The People-to-People Health Foundation, Inc.

pilot referral feedback mechanisms in select locations throughout the state with select community organizations who are willing and able to participate.

OHCA will need baseline data and information to properly measure MCOs' performance on social risk mitigation strategies. MCOs can use the initial years of the program to work with providers to establish baseline data for enrollees (via screenings, SDoH z-code diagnoses on claims, etc.). This information will be used to track health outcomes and medical spending for those individuals over time as their SDoH needs are addressed. OHCA may also wish to consider updating the current SoonerCare fee schedules to reimburse for SDoH z-code diagnoses, which would encourage providers to properly screen for and document social needs for their patients.

How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

MCOs can work collaboratively with OHCA, the Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma provider community to continue to improve access to evidence-based behavioral health care through multiple different mechanisms. For example, MCOs can support existing and/or create new opportunities to train and educate providers about evidence-based behavioral health care services available to SoonerCare members. Through its provider agreements and value-based care arrangements, MCOs can promote providers' use of SBIRT to improve outcomes for individuals with substance use disorders and/or individuals who may be at-risk of substance use disorders. To streamline evidence-based care authorization requirements for providers, MCOs should be encouraged to follow the same and/or similar authorization requirements as currently outlined by OHCA for services such as medication assisted treatment for opioid use and program of assertive community treatment (PACT) services.

What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

When provided with sufficient flexibility, value-added services can serve as a cost-effective alternative to traditional Medicaid benefits not otherwise offered. They can be utilized to incentivize healthy behaviors, or to support individuals during critical moments of their health care journey such as a transition from an inpatient facility to a community setting.

MCOs should have some discretion to develop services that have a reasonable expectation of improving or maintaining health or overall function of their enrollees. This includes "nontraditional" benefits that target SDoH in addition to approved value-added services. Nontraditional benefits could include a variety of items, such as: additional transportation coverage and meals, costs of housing applications, costs of obtaining documents such as birth certificates or state identification cards necessary for eligibility and job applications, toiletries/hygiene items, etc. Nontraditional services promote health and wellness and help address SDoH related needs. These benefits are often leveraged in emergency situations and/or when these resources are not available through local community organizations and non-profits.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Access to safe, reliable, and timely transportation options is critical for members to attend health care appointments and to refill prescriptions at pharmacies – which ultimately improves health outcomes and lowers medical costs. Ride-sharing services such as Uber, Lyft, as well as any local Oklahoma ride-sharing services should be a covered transportation service for rides to medical appointments and to the pharmacy. Additionally, current SoonerRide provisions, such as allowing for up to three children to be transported to attend medical appointments, will be important to keep in place. OHCA may also wish to consider expanding this coverage to allow parents to take up to three children to non-urgent medical appointment visits as well. This would help with preventive visit and immunization compliance rates – particularly for parents with multiple small children and infants who may not have access to childcare.

Quality and Accountability

What mechanisms should the state use to incentivize MCOs to improve member outcomes?

To encourage MCOs to improve member outcomes, OHCA should incentivize quality performance models that increase collaboration among members, providers, and MCOs by emphasizing value-based arrangements and implementing a MCO Pay-for-Performance (P4P) program – using the first full year of the program as a baseline year.

In provider value-based arrangements, MCOs can incorporate quality performance targets tied to financial incentives or penalties into provider contracts. Structuring provider contracts around quality performance encourages collaboration on shared goals, which in turn helps providers to meet quality performance targets and improve member health outcomes.

OHCA's MCO P4P program should include a focused set of quality performance measures, include a baseline measurement year and performance targets for subsequent years, and financial bonuses associated with meeting targets. To provide the necessary focus on improving care outcomes, the MCO P4P program should be comprised of a limited number of performance measures (i.e., a maximum of ten measures). This will allow MCOs and providers to implement focused quality improvement processes to make the greatest impact on the state's health priorities. The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures are one of the nation's most used quality performance improvement tools. OHCA should use HEDIS as performance measures in a P4P program, and selected measures should align with the needs of SoonerCare members and focus on state priorities across physical and behavioral health.

The first full calendar year of the MCO contract should be considered a baseline measurement year for the selected measures (i.e. no financial incentives should be associated with HEDIS measure performance for calendar year (CY) 2022). Instead, MCOs should be responsible for developing performance dashboards to track and monitor performance trends and begin to formulate interventions to increase HEDIS performance for future years. For example, MCOs

could provide OHCA with quarterly reporting and participate in collaborative meetings with OHCA and the other SoonerCare MCOs to provide feedback regarding the P4P program. For subsequent contract years (CY2023 and beyond), MCOs could be incentivized for meeting performance measure targets based on a variety of methodologies. For example, OHCA could leverage national or regional NCQA benchmarks to set benchmarks that MCOs are required to meet for their assigned membership. Another suggestion for setting benchmarks could be to incentivize MCOs for achieving year-over-year improvements.

What are the most important indicators of MCO performance? Why?

Important indicators of MCO performance are often reflected in accreditation status and various measures of quality performance and improvement. Earning and maintaining accreditation demonstrates that a MCO is committed to the experience of its members, providing high quality coverage, and compliance with industry standards. In addition to accreditation, quality performance indicators such as HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and indicators such as potentially-preventable events (based on 3M methodology) may be leveraged to monitor MCOs' performance.

What measures of health outcomes should be tracked?

OHCA should require MCOs to develop a robust Quality Improvement Program that is designed to engage both members and providers to achieve high quality health outcomes. The quality model should be structured to align with OHCA's priorities to ensure there is added value when bringing Medicaid Managed Care into the landscape. In addition to focusing on key preventive measures such as annual wellness visits and immunizations, we recommend tracking health outcomes by utilizing the HEDIS measures which align with OHCA's priorities. Below are example measures which OHCA may wish to consider:

Tobacco Use

1. **Medical Assistance with Smoking and Tobacco Use Cessation-Discussing Cessation Strategies Measure (MSC)**

This measure promotes education on smoking cessation methods/strategies to adults age 18 and over who are current smokers or tobacco users. Interventions may include member outreach to provide smoking cessation, engaging tobacco users in care coordination, educating providers on smoking cessation resources and medications available, and referrals to the Oklahoma Tobacco Helpline. To support OHCA's strategies to address SDoH, MCOs may also consider employing community health workers (CHWs) to help provide smoking cessation education to members.

Opioid-related Overdose / Behavioral Health Access

2. **Use of Opioids at High Dosage (UOD)**
3. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation of Opioid Dependency Treatment**

4. **Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Days**

MCOs should develop quality improvement models that align physical health with behavioral health (BH). As opioid misuse and access to BH care continue to be national trends, it will be important to focus attention on caring for members' BH needs through an integrated physical and behavioral health care coordination approach. The three measures identified above can support OHCA's goals of preventing opioid-related deaths and increasing behavioral health access. For example, MCOs may choose to use peer support workers or providers' care coordination teams to conduct outreach to members who have been over-prescribed opioids or have a recent diagnosis of drug dependency. Oklahoma's Health Information Exchange (HIE), MyHealth Access Network, may be leveraged to follow-up with members who had a recent ER visit for mental health to help coordinate a follow-up appointment for the member. Other examples of interventions to help address OHCA's priorities could include: provider education to providers that are over-prescribing, pharmacy lock-ins when opioid overuse is identified, and linking members with behavioral health and detox providers as needed. MCOs should be allowed flexibility in implementing these different types of interventions to best meet the needs of their members and providers.

Childhood Obesity

5. **Weight Assessment for Children and Adolescents (WCC): BMI Percentile Documentation**

This measure identifies the percentage of children ages 3-17 who had a primary care visit and had their BMI measured and documented. Interventions may include member outreach to individuals to schedule well-visits, education to providers on BMI and nutrition, and connecting members with community resources. MCOs may also choose to offer "value-added" benefits such as fresh produce delivery, exercise classes, or fitness tracking devices.

Diabetes

6. **Comprehensive Diabetes Care (CDC): HbA1c Testing**
7. **Comprehensive Diabetes Care (CDC): Retinal Eye Exam**

There are several HEDIS measures related to care for members with diabetes. Two recommended HEDIS measures are the HbA1c measure which promotes having a yearly HbA1c test, and the Eye Exam measure which promotes a retinal eye exam to test for diabetic retinopathy. Both measures are important indicators in managing this chronic condition and align with OHCA's state priority of addressing diabetes. Interventions may include partnering with a vision vendor to conduct member outreach to schedule visits for exams/labs, and leveraging an internal Diabetes Disease Management program to provide education on chronic condition management and care coordination. By participating in the HIE, MCOs will also be able to ensure that duplicative tests/labs are not conducted, and that available data is used to support care coordination for members.

Pregnancy Outcomes

8. **Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care**
9. **Prenatal and Postpartum Care (PPC): Postpartum Care**

These pregnancy HEDIS measures support healthy pregnancies and birth outcomes by measuring the receipt of clinically recommended prenatal and postpartum care during and after pregnancy. MCOs could implement a robust maternity program to help members better understand and manage their pregnancies. Through this program, MCOs could leverage care coordination and CHWs to conduct member outreach and education on prenatal care, postpartum care, breastfeeding, and caring for a newborn. MCOs may also offer "value-added" benefits to provide members who attend prenatal/postpartum visits with items that support them in their pregnancy, such as a car seat.

Cardiovascular Disease

10. **Controlling High Blood Pressure (CBP)**

This measure aligns with OHCA's priority of addressing cardiovascular disease by measuring the percentage of members with a hypertension diagnosis who have adequately controlled blood pressure (BP). Interventions to address this chronic condition may include provider education, member outreach to individuals to schedule well-visits, and targeted interventions for those with blood pressure medication adherence barriers.

Care Management and Coordination

How can utilization management tools work best for members and providers?

Utilization management processes and tools work best for members and providers when the intent is not to deny care and claims – but rather when they are used to ensure the right level of care at the right time. MCOs should be allowed flexibility to implement utilization management tools in a streamlined manner to limit pre-authorization requirements (where appropriate) and reduce provider administrative burden overall.

How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

OHCA should encourage MCOs to work together to create consistency, where possible, for utilization management processes for special provider types / services – in particular for vulnerable populations or complex service needs. This could include OHCA assembling a collaborative workgroup of clinical leaders from MCOs to establish consistent clinical utilization management policy where possible. In some instances, however, requiring consistency across MCOs for utilization management processes may have the unintended result of increasing provider administrative burden. Through MCOs value-based care arrangements, utilization management processes and prior authorization requirements may be waived or reduced based on the provider's performance and the reimbursement methodology under the agreement.

Additionally, MCOs often create tailored arrangements – particularly with hospitals and other inpatient facilities – based on regional utilization patterns population needs, and level of care/services provided at the facility. Being overly prescriptive or requiring too much consistency across MCOs may stifle the ability of an individual MCO and provider to collaborate on solutions to safely and effectively treat patients at the appropriate level of care. MCOs should demonstrate the ability to provide tools to providers that allow self-service and transparency in decisions and status of request.

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

OHCA should carefully consider requirements which dictate specific approaches on *how* MCOs meet enrollees' behavioral health needs through network, care delivery, and care coordination. Stringent contract requirements on specific mechanisms and programs often limit an MCO's ability to work creatively with providers and community organizations on innovative care models. Instead, OHCA should consider outlining the intended behavioral health care outcomes that MCOs must achieve for its enrollees and allow MCOs flexibility in their approaches to meet the target outcomes. OHCA may also wish to incentivize MCOs for achieving targeted behavioral health related measures, such as medication adherence and compliance with follow-up appointments with primary care and behavioral health providers.

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

OHCA should allow MCOs to be creative in their approaches to improve coordination for members with chronic and complex health care needs. For example, MCOs should be encouraged to leverage different approaches based on members' needs and preferences, such as: digital engagement tools, targeted provider and community partnerships for different chronic conditions, and flexible member incentives.

What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

MCOs should be able to demonstrate their awareness, preparedness, and experience working with these unique populations. For example, for the AI/AN population, MCOs should demonstrate their proven ability to work collaboratively within the legal and regulatory framework of Oklahoma's Tribal Nations, as well as with existing programs and services that serve this population.

MCOs should be encouraged to work collaboratively with provider partners to reduce barriers to care and improve coordination for special populations. Each special population covered through the SoonerCare managed care program will necessitate tailored approaches by MCOs and the provider community, which will take time to establish. It is critically important that MCOs offer a statewide network to accommodate unique needs of this population (i.e. the geographic

movement of children foster care, highly specialized providers for the medically fragile, etc.) MCOs who can demonstrate Oklahoma provider relationships will be best-positioned to leverage their partnerships to more efficiently improve coordination of care across providers' patient populations.

To reduce barriers to care, OHCA and MCOs will need to ensure appropriate coverage of medically necessary services. In particular, OHCA and MCOs should focus on compliance with mental health parity rules by ensuring all relevant services are fully funded as covered services. MCOs should also have experience working with MyHealth Access Network (HIE), as the need to have electronic medical history and care planning information will be essential to improving the coordination of care and services for these populations. MCOs should also demonstrate their ability to engage with enrollees, their families, and caregivers to support navigation of benefits, and non-covered services available through Oklahoma's community resources.

Member Services

What metrics should be used to measure MCO performance with regards to member services?

Understanding the critical role MCOs play in a Medicaid member's health choices, it is important for OHCA to establish metrics and standards that hold MCOs accountable to ensure member's questions and concerns are addressed in a timely and respectful manner. OHCA could use administrative metrics such as call abandonment rates, call answer timeframes, average member services call wait times, and overall service levels. Perhaps more importantly, though, OHCA may wish to consider various member satisfaction indicators and surveys, such as CAHPS or variations of a net promoter score (NPS), to measure MCO performance with member services.

How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

MCOs can best serve individuals who primarily speak a non-English language or who may not understand health care terminology by first embracing diversity, inclusion, and cultural competency programs within their organizations. MCOs should be required to demonstrate they understand the unique needs of Oklahoma's communities and their ability to serve those communities. MCOs should also commit to having diverse member-facing staff (member services, care coordination, etc.) who reflect the communities and members they will serve.

Cultural competency training can help MCO staff and providers understand a member's concepts of health and healing, perceived causes of illness, behaviors of members who are seeking care and their attitudes toward their providers. Additionally, cultural competency training can help MCO staff meet the social, cultural and linguistic needs of their population, this in turn can help address member's language and health literacy challenges.

MCOs can also serve individuals who primarily speak a non-English language by offering readily available interpreter services to help members obtain information about their benefits,

access to medical services and ability to understand policies, procedures and available MCO resources. Interpreter services should be provided at no charge and comply with applicable federal and state laws. Interpretative services to consider include: large print, Braille, oral interpretation, audio and sign language.

MCOs will be most effective in serving member's language and communication preferences if this information is collected and maintained through Oklahoma's Medicaid eligibility processes and passed to MCOs on their enrollment file. It would be helpful through the Medicaid eligibility and redetermination process, to collect and confirm information such as: language preferences (spoken and written), race, ethnicity, household/family members with Medicaid benefits, current physical and mailing addresses, current cell phone number and email address(es), consents to receive calls and texts (with ability to opt-out) from MCOs about available benefits, services, etc. If this information is accurately provided to MCOs on their enrollment files, this would allow MCOs to effectively craft a tailored experience for members.

Health education and literacy programs are critical component of MCOs' programs to improve member health outcomes. Health literacy among members ranges across a Medicaid program and a one size fits all approach to health education is not effective. Therefore, OHCA will want to ensure MCOs have the flexibility to create and tailor programs to meet the unique needs of their enrolled membership. For example, MCOs may find that hosting in-person health education programs for some areas of the state or with certain populations are most effective. In other geographical locations or for different member demographics, these types of in-person events may not be well-attended, but members would prefer to engage via a mobile app or text messaging campaign to receive health literacy related information.

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

MCOs should be allowed to leverage technology - such as web-based applications, texting, and email engagement - to offer cost-effective, relevant and reliable solutions that address members' unique needs. Technology allows members to access and manage their health in real time. According to a 2018 Deloitte survey of U.S. health care consumers[2], most adult Medicaid beneficiaries own mobile technologies, use them for a variety of health purposes, and are interested in trying new digital health applications in the future. The survey found that adult Medicaid beneficiaries own smartphones (86 percent) and tablets (69 percent) at the same rates as the general adult US population (86 percent and 72 percent, respectively), and at only slightly lower rates than those with employer insurance (94 percent and 79 percent).

Many individuals are more likely to engage with their health plan and providers via text or mobile app (rather than telephonically or in-person). However, MCOs will need the support of OHCA to fully leverage technology solutions. At the point of Medicaid eligibility determination, re-determination, and enrollment with MCOs, it would be helpful for the state to stipulate that coverage through the SoonerCare managed care program will require an individual to engage

[2] Medicaid and Digital Health, Findings from the Deloitte 2018 Survey of US Health Care Consumers

with their assigned MCO. At these check-points, OHCA should include a request for consents for outbound phone calls, texting, and emails. The most current member contact information should also be collected at these intervals and provided to MCOs through the enrollment process. MCOs should also be provided this prior expressed consent information upon a member's enrollment with the MCO. MCOs should continue to offer members the option to opt-out of text messaging, emails, and calls. However, the prior expressed consent will allow OHCA and MCOs to comply with the Telephone Consumer Protection Act (TCPA).

How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

MCOs should be creative in their approaches to communicate with members who do not have a mobile phone, computer, or reliable internet service. MCOs can leverage standard practices such as mail, telephonic engagement, and in-person visits. MCOs may also choose to leverage local community organizations and providers to communicate with members on behalf of the MCO. MCOs selected for the SoonerCare program must demonstrate that they have the proven capacity to bring people together and promote social interaction in Oklahoma. MCOs must be visible in the Oklahoma communities they serve. MCO community liaisons and leadership presence at local events can serve as an important opportunity to connect with members with limited digital resources by connecting with them face to face.

How can MCOs communicate with members and receive regular input and feedback on program improvements?

MCOs should be encouraged to take various approaches to receive regular feedback and input on program improvements. This could be accomplished by regularly requesting general feedback through routine touchpoints with member services and care coordination teams, actively seeking feedback through outbound call, texts, and/or email campaigns to ask members about specific program attributes, or through member focus groups or advisory boards. Member advisory board meetings – whether held in-person or virtually – serve as a great forum to collect feedback on plan program policies and overall member experience. They also present an opportunity for MCOs to brainstorm with members on tactics and strategies to address emerging trends and topics in Oklahoma.

What tools and resources would help members search for providers? What information should be provided?

MCOs should provide members with an online or mobile provider directory / provider finder to allow members to search for in-network providers by location, availability, and specialty type. MCOs should provide information, such as: physical address, phone number/contact information, office hours, performance ratings, provider group or facility affiliations, education / credentials, languages spoken, and whether the provider is accepting new patients. The online provider directory should be accessible to the public (without a requirement to be a MCO member or establish a login) via the MCO's public website.

As information in provider directories changes frequently, MCOs will need to ensure regular maintenance of provider demographic information online. For members who do not have the option or ability to leverage an online provider directory, members should be able to call the MCOs' member services call center to be assisted with finding providers to meet their needs. Members should also be able to call to request a printed version of the provider directory be mailed to them, if they so choose. As information in provider directories often become 'out of date' as soon as it is printed, MCOs should not be required to mail a directory to all members and should be given reasonable timeframes (i.e. 10 business days) to fulfill printed directory request from members to ensure information is accurate and useful to the member.

Provider Payments and Services

What metrics should be used to measure MCO performance with regards to provider services?

MCO provider services performance may be measured and assessed in a variety of ways. OHCA may wish to monitor provider services call center performance metrics through standard administrative metrics such as call abandonment rates, timeliness of calls answered, average wait times, and return call timeliness. Additionally, quality performance metrics and performance-based payment activities should be monitored on an annual basis. OHCA and selected MCOs should collaborate to create a provider satisfaction survey, which could be administered annually to measure and obtain feedback on key provider services functions, such as: provider relations and communications, assistance with claims, billing, and authorization processes, care coordination and clinical management support, and issue/complaint resolution. Standardizing a provider survey across MCOs will help OHCA and MCOs to assess areas of opportunities to improve provider services function performance.

Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

For the vast majority of provider types, OHCA should not stipulate specific levels of reimbursement for the program. The negotiation of provider agreements, including reimbursement levels, will vary drastically based on the provider type/specialty, the unique individual provider and the MCO. Establishing minimum level reimbursement requirements could have unforeseen negative impacts on an MCO's and provider's ability to collaborate, innovate, and create value-based care arrangements that may improve outcomes and benefit providers financially.

Instead, OHCA should allow for the reimbursement structure between MCOs and providers to be a competitive component of the managed care model. Providers may choose not to contract with MCOs who offer contracts with significantly lower rates than what is currently offered in the SoonerCare fee schedules. This will negatively impact the MCO, as their contracted network is one of the primary differentiators for members when selecting and enrolling in a health plan. Therefore, MCOs who are not able to build robust provider networks due to offering low

reimbursement rates will not be selected by SoonerCare members and will also not meet OHCA requirements for network adequacy and access.

To sustain provider compensation, OHCA should routinely evaluate claims and encounter experience data by region, hospital, and at the provider level. MCOs' medical loss ratios should also be reviewed to evaluate the adequacy of provider compensation. In addition, to protect select safety net provider types such as FQHCs and RHCs, OHCA may wish to include language in MCO contracts requiring certain reimbursement levels. For example, for FQHCs or RHCs who have elected to receive the prospective payment system (PPS) encounter rate, OHCA may consider requiring that MCOs reimburse contracted FQHCs and RHCs at least the same amount as the full per-visit encounter rate for covered services.

What is appropriate for timely payment of claims?

As base contract requirements, OHCA should require MCOs to follow federal and state statutes, whereby 90 percent of clean claims should be paid within 30 days of receipt (42 CFR 447.45(b)), and 100 percent of clean claims should be paid within 45 days of receipt (36 O.S. 1219).

From a competitive perspective, however, it is in an MCO's best interest to reimburse providers more quickly. Timely reimbursement is key component to building and ensuring provider satisfaction with an MCO. Additionally, ensuring providers have timely and adequate cashflow to invest in resources and capabilities benefits providers, patients, along with MCOs in their ability to meet health outcomes and quality performance requirements.

What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

An MCO's ability to build strong relationships with providers and offer exceptional provider service promotes competition and innovation among MCOs. OHCA should structure the MCO provider services functions and requirements in way where MCOs are able to create innovative solutions to collaborate with providers to reduce/eliminate provider administrative burden and support providers in improving patient outcomes.

However, OHCA may wish to explore the standardization of certain provider services functions which are heavily regulated through existing state and federal guidelines and do not allow for variation across MCOs. For example, some states have standardized and/or centralized the credentialing and re-credentialing of Medicaid providers to reduce both MCO and provider administrative burden. This may be done by requiring MCOs to work together to create standardized credentialing / re-credentialing forms. OHCA may also require MCOs to leverage one entity for primary source verification and the collection and storage of provider credentialing (and re-credentialing) information, such as Council for Affordable Quality Healthcare, Inc. (CAQH). Alternatively, OHCA may wish to fully centralize credentialing / re-credentialing functions using a centralized credentialing verification organization (CVO), such as Aperture. OHCA should work with providers and selected MCOs on such standardizations to discuss any

potential barriers or issues and assess reasonable timeframes prior to rolling out requirements and implementation dates.

How can MCOs best communicate to providers about updates and changes to plan policies?

MCO communications with providers are most effective when tailored to how providers wished to be communicated with. This means MCOs should be prepared to communicate updates and changes to plan policies through multiple channels, for example: online, telephonic and in-person meetings with individual provider practices, and through webinars or provider forums for large groups of providers to attend.

How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

BCBSOK understands that maintaining strong provider relationships is our most important tool to improving health of our members. We have learned through experience that this means tailoring our provider services support functions based on providers' individual preferences. For example, some provider practices prefer regularly scheduled in-person touchpoints with our provider services representatives to be provided information around claims, billing, clinical practice guidelines, quality performance, etc. Some of these same providers have expressed they will not access this information through portals (either due to current technology limitations or personal preference).

We also have many contracted providers at the opposite side of the spectrum who prefer to access all plan and performance information online through our website and secure provider portal – and then contact us only if they have questions. It's important that MCOs are able to offer a wide range of provider services support functions to providers based on the provider preferences. Therefore, it is equally important that MCOs are not required to provide all service functions to all providers, as in doing so, OHCA may inadvertently increase provider administrative burden for providers who are not able or willing to engage with MCOs in specific ways.

What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

Over the course of the SoonerCare Program, MCOs should be tasked with implementing shared accountability and/or value-based purchasing (VBP) models with provider groups. Implementation of these arrangements will align the goals of the provider and MCO with OHCA's goals for the SoonerCare Program. MCOs should consider including quality performance as an indicator in VBP arrangements with providers. Providers should be incentivized for meeting set benchmarks for HEDIS measures which align with OHCA's priorities. An emphasis on value-based arrangements with providers and an MCO P4P program

structured as outlined in the "Quality" section of this response will unify efforts across health plans, hospitals, and providers to improve population health outcomes.

Robust data sharing processes are essential to ensuring providers' success in shared accountability models. To improve quality performance outcomes, some providers may benefit from having access to data to understand gaps in care and opportunities to close gaps for their patients. MCOs may assist, for example, by sharing gaps in care and performance data with providers prior to onboarding into VBP arrangements so they may better understand their areas of opportunity.

How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

OHCA should allow MCOs flexibility in supporting primary care providers in caring for their patients. Provider practices differ drastically across the state in terms of current infrastructure, capabilities, and patient population mix. Depending on provider need and their engagement preferences, MCOs can support primary care providers by making technical assistance resources, reporting platforms, and analytical capabilities available to providers to make informed decisions regarding their patients/MCOs' members.

MCOs should also meet with provider groups who are struggling to close care gaps for members. Through these meetings, MCOs and providers can share best practices and discuss opportunities to implement targeted interventions for improving HEDIS performance and health outcomes for members / patients.

Network Adequacy

How should MCOs work with providers to ensure timely access to care standards are met?

MCOs and providers should work collaboratively to ensure timely access to care standards, such as timeliness of appointments for routine, urgent, and emergency needs, are met. These standards are not meant be an administrative burden on providers but rather to support healthy outcomes and to reduce medical spend by preventing clinical needs from worsening when appropriate care is not received in a timely manner. MCOs should include parameters and expectations for providers regarding access to care standards in provider manuals and provider education. MCOs can monitor timeliness of appointments through periodic assessments with providers of their practice processes for appointment reservations and medical record reviews.

Additionally, MCOs may wish to explore the inclusion of access to care standards – including the availability of evening and weekend appointment times – into their value-based care reimbursement arrangements. This should not necessarily be a requirement for MCOs or providers – as in some cases this is not feasible nor appropriate to request. However, creative reimbursement models should be encouraged and may give providers the financial support required to meet and increase access to care for SoonerCare members over time.

What are reasonable time and distance standards in Oklahoma by provider type?

Time and distance standards need to be carefully developed based on the number and location of providers who currently participate in Oklahoma Medicaid. Without this information in a format which can be analyzed, it is difficult to provide specific recommendations of reasonable time and distance standards for the Oklahoma SoonerCare program by provider type.

However, in general, OHCA should attempt to define time and distance standards by county and region type. For example, in New Mexico, the state has defined Medicaid MCOs network time/distance standards by Urban, Rural, and Frontier designations. Each county is provided a designation and a specific network time / distance standard by provider type. For example, for access to primary care providers (PCPs):

- Ninety percent (90%) of Members residing in counties which have been designated as "Urban" shall travel no farther than thirty (30) miles;
- Ninety percent (90%) of Members residing in counties which have been designated as "Rural" shall travel no farther than forty- five (45) miles; and
- Ninety percent (90%) of Members residing in counties which have been designated as "Frontier" shall travel no farther than sixty (60) miles.

OHCA should outline an exception process for MCOs to follow when certain provider types/specialists simply do not exist to allow for these time and distance standards to be met.

The availability of telemedicine visits should also be a key consideration in monitoring provider network adequacy and access to services. While some care and services cannot be provided through telemedicine, the COVID-19 pandemic has shown that the healthcare delivery system can successfully embrace the use of telemedicine as a viable alternative to many outpatient services. OHCA should consider allowing the availability of provider service types via telemedicine as part of the traditional 'time and distance' standards for in-person care. For example, if enrollees can access primary care and specialist services through telemedicine from home or a telemedicine site from a physical provider office site (within the time/distance standards from the member's residence) - this should be considered to meet the requirements developed for network adequacy standards.

How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

Successful MCOs must be able to demonstrate that they have a culture and mission capable of attracting and retaining providers to participate in their network. MCOs must have experience recruiting physicians to serve in rural and native communities in Oklahoma. MCOs that can demonstrate existing long-standing relationships with providers across the state and offer value-based care arrangements to providers in each of these products are in a unique position to recruit more Oklahoma health care providers to participate in Medicaid.

Based on experience in other states, Medicaid members – providers' patients – move across coverage types (i.e. from employer plan to Medicaid, Medicaid to Marketplace, etc.). Medical

providers entered the profession to help individuals and if there is an option to maintain their provider-patient relationships, providers often want to do so. Providers, therefore, often prefer to contract with MCOs who serve individuals across product types. MCOs should be able to demonstrate the ability to leverage existing Oklahoma provider relationships in order to recruit and retain more providers to participate in Medicaid.

How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

MCOs should be flexible and creative in their approaches to supporting workforce development opportunities across Oklahoma, particularly for specific provider types such as primary care, behavioral health, and dental providers. For example, through their value-based care arrangements, MCOs should be allowed to include reimbursement methodologies and/or incentive payments that could be used toward advanced education scholarships, continuing education credits, or specialty education training by the provider practice/group.

Grievances and Appeals

How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

MCOs should be required to track and trend member complaints and grievances, including resolution timeliness. This information and analyses should be provided by MCOs to the state on a routine basis to help the state identify patterns across MCOs which may be indicative of system-wide issues.

OHCA should define processes for members which outline specific timeframes for which their MCO has to address their concerns. If MCOs do not sufficiently address a member's concerns or issues within the timeframes outlined, OHCA may wish to put in place a state complaint process for members to leverage. This would be a pathway for only those members who can demonstrate they have gone through the initial complaint/grievance process with the MCO and the MCO has failed to address their concerns within the required timeframes.

How can the state and MCOs use appeals data to improve utilization management and access?

The state and MCOs should track and trend appeals data to inform utilization management practices and support access to care. Many Medicaid MCOs assess appeals data and outcomes through their normal course of business to inform utilization management guidelines and provider education. For example, when appeal denials regarding specific services are consistently upheld - or consistently reversed – MCOs use this information to change their provider education processes and/or their utilization management guidelines to reduce administrative burden for providers.

Administrative Requirements

How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

OHCA and MCOs who currently operate and have experience in Oklahoma are well-positioned to streamline data sharing using the MyHealth Access Network (HIE) to improve patient care and outcomes. Similar to practices in-place today, if members wish to opt-out of sharing data through the HIE, they can do so by completing the opt-out forms online.

MCOs and providers should work collaboratively to share various sources of data, including care plans, quality performance, utilization and efficiency metrics, etc. to facilitate patient care and support positive outcomes. MCOs and providers should be allowed to work on a case-by-case basis to define the necessary data sharing required, as providers have differing capabilities and infrastructure to support data exchange processes.

How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

MCOs may deploy various tools and best practices to help identify and prevent fraud, waste, and abuse. Some examples include: operation of FWA referral hotlines; pre-payment and post-payment reviews; ongoing claims data audits to identify aberrant billing practices; assessments of over and underutilization at the individual provider and practice level as well as for individual members and populations; and pharmacy and provider lock-in programs for members who may be at-risk.

MCOs who currently serve employer, Marketplace, and Medicare populations in Oklahoma will have an advantage in identifying fraud, waste, and abuse across Oklahoma's health care delivery system. These MCOs can identify patters and practices through data mining and advanced analytic algorithms – which become more efficient and accurate when data can be aggregated across multiple product lines to detect trends.

Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

OHCA should carefully consider whether a requirement for awarded MCOs to offer health plans on the Oklahoma Health Insurance Marketplace is in the best interest of Oklahoma and the stability of the Marketplace.

OHCA may wish to include in its evaluation process considerations for MCOs who currently offer a plan on the Oklahoma Marketplace. SoonerCare enrollees are likely move between SoonerCare MCOs to and from a Marketplace plan, to and from an employer sponsored plan, or to Medicare. Ensuring continuity of care for members – no matter their coverage type – will be important to efficiently implementing the new SoonerCare program, and for improving health

outcomes and controlling costs over time. MCOs who currently offer coverage in the Marketplace – as well as to employer and Medicare covered individuals in Oklahoma - should be given preference as part of OHCA's SoonerCare MCO selection process.

CareSource®

SoonerCare

Comprehensive Managed Care Program

Request for Public Feedback in Program Design

80720200002

Oklahoma Health Care Authority

August 17, 2020

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SoonerCare Comprehensive Managed Care Program

Introduction

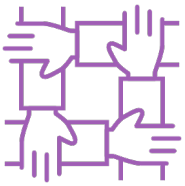
In 1989, CareSource was the strategic partner of choice selected by the State of Ohio to introduce managed care to their Medicaid beneficiaries. Managed care replaced traditional fee-for-service (FFS) and ushered in a new health care model that still benefits the State, our partners and the populations we serve. The CareSource mission is to make a lasting difference in our members' lives by improving their health and well-being through our member-focused approach. CareSource is currently the largest nonprofit managed care provider in Ohio and has expanded to Indiana, Georgia, West Virginia, and Arkansas. Since the passage of the Affordable Care Act (ACA) in 2010, the Medicaid program has experienced significant growth, and CareSource remains at the forefront of driving change and having a positive impact in the lives of enrollees. Currently, we have a flexible operating model that allows us to either leverage a nonprofit or for profit HMO model that allows us to serve as a fiduciary agent, optimizing the State's funds for enhanced member services and value based purchasing incentives. Our fiduciary responsibility includes directing more of our health care dollars to member care.

We have a flexible operating model that allows us to either leverage a nonprofit or for profit HMO structure that allows us to serve as a fiduciary agent, optimizing the State's funds for enhanced member services and value based purchasing incentives.

Our fiduciary responsibility includes directing more of our health care dollars to member care.

CareSource's mission is to work with our state partners, their constituents, enrollees, members, and the provider community to drive greater value and voice in healthcare delivery. This mission is even more important, given the current COVID pandemic and expansion of Medicaid eligibility, which has led to a growing demand for health care services for populations with diverse and special needs. States must prioritize the ways in which they stretch federal dollars to adapt to the changing health care landscape and shifting demographics. As a result, Medicaid programs have turned to MCOs to leverage care management, drive quality, improve access to care, promote accountability, and contain costs. CareSource has the experience, expertise, and passion to drive Medicaid modernization efforts and enhance state resource management.

Partnering for Success



We have demonstrated experience in working with states as partners to solve complicated issues within managed care, including budget predictability, expanded oversight and fraud protection, and carved-in coverage for potentially costly populations.

To maximize health outcomes and member satisfaction, we utilize a multifactor approach, working with key state stakeholders and members of the community to implement programs that address the physical and behavioral health needs of our members while addressing barriers to care. CareSource recognizes the value of strong relationships with leaders in the community to gain insights and local market knowledge. We have demonstrated experience in working with states as partners to solve complicated issues within managed care like budget predictability, expanded oversight and fraud protection, and carved-in coverage for potentially costly populations.

Stemming from our nonprofit roots, our core motivation and dedication are fundamental in how we serve the community and provide health care with compassion and innovation. To provide high quality and lower cost care, we manage potentially costly populations and focus on providing comprehensive services to support all aspects of our members' health and well-being. This requires a targeted approach that emphasizes purchasing value based care from providers rather than volume based care. These tenets create the infrastructure, which helps us to reach more beneficiaries and manage beneficiary health outcomes while maintaining a consistent and transparent budget.

CareSource builds relationships and systems so that providers can easily care for our members. We do this by providing fully automated prior authorization process, eliminating referrals on many services, streamlining operational functions to minimize difficulties for our health partners, and making timely and accurate claims payments, including real time claims adjudication solutions for specific providers. Real time adjudication streamlines both the revenue cycle for the provider and turns the health care encounter into a more customer-friendly transaction for the patient. For rural providers, telehealth / telemedicine claims, and specific provider populations where access is critical, CareSource recommends that plans be required to have this functionality as it pertains to their specific needs. Value based purchasing ensures that MCOs, including CareSource, provide services based on member needs while simultaneously aligning with state health priorities. CareSource leads other plans on this front by embracing value based purchasing to control costs.[1]

1 (CareSource, 2020)

CareSource recommends that plans be required to have real time adjudication functionality as it pertains to their specific needs.

For rural providers, telehealth / telemedicine claims, and specific provider populations where access is critical

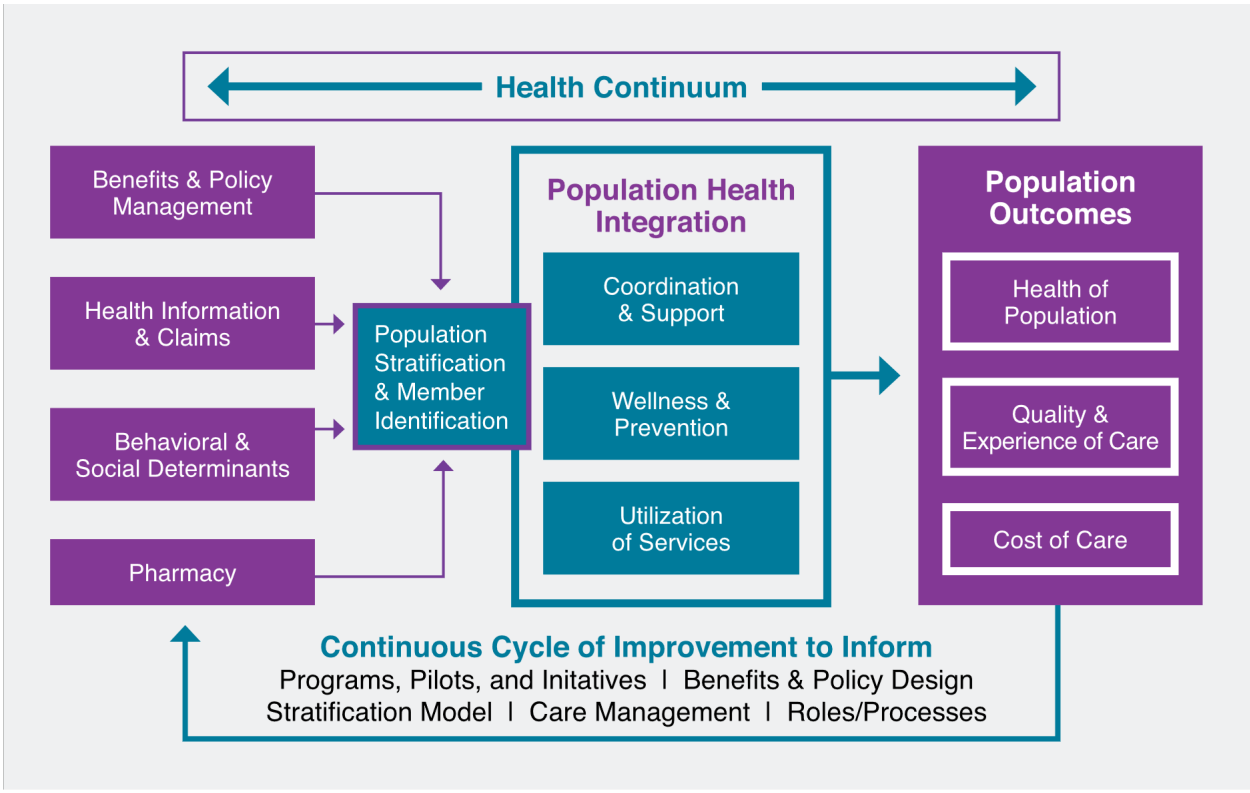
Leading the Way in Addressing Social Determinants of Health

Our care management model aims toward member empowerment and has a special focus on social determinants of health (SDOH) to address member needs in a holistic way. This is and has always been our focus since we first opened our doors in Ohio. The suite of programs that CareSource offers targets the underlying causes of health related challenges, including affordable housing, behavioral health, care coordination, job training, and access to healthier food. Traditionally, FFS programs have not addressed these underlying causes of health related challenges; however, we realize that achieving health is a multifaceted problem. CareSource embraces the SDOH model of care and ensures the entire well-being of its members.

CareSource JobConnect™

Figure Data as of 12/4/18

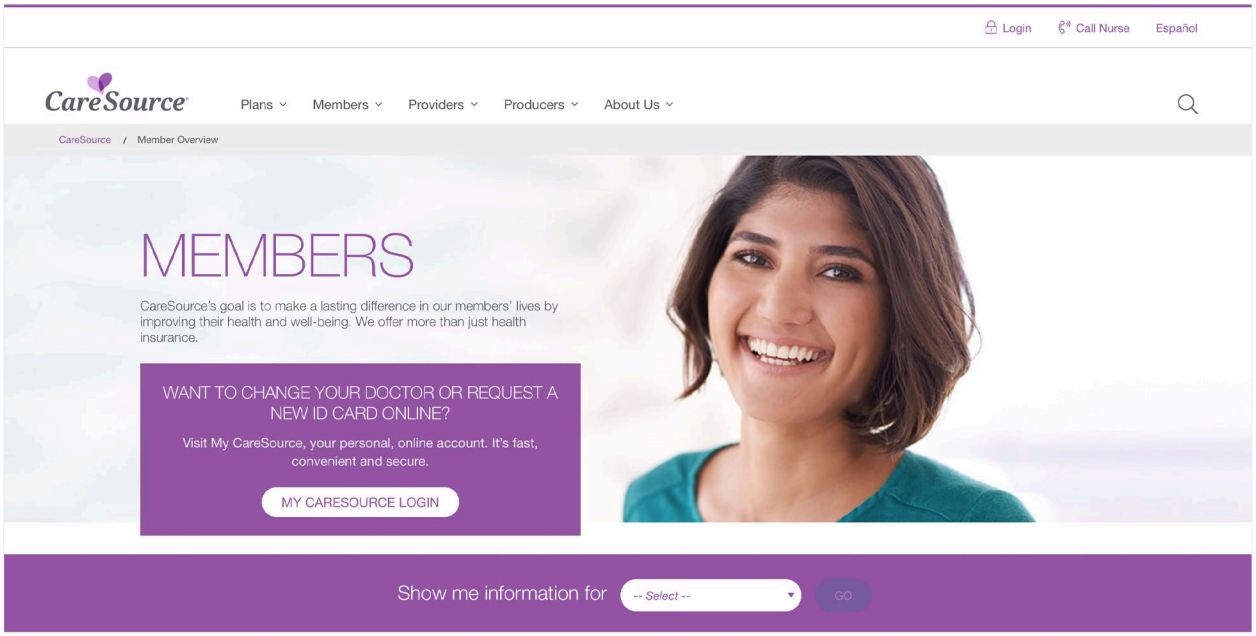
SDOH Model of Care
Promoting Member Empowerment



CareSource is at the forefront of advancing technology infrastructure within our markets. To build out capacity, MCOs are improving care coordination by investing in technology and clinical management platforms. CMS has taken note of this trend in Medicaid Information Technology and expanded funding for states to make technology-related investments.[2] CareSource members always have access to our member portal, MyCareSource, where they can request a new ID card, review claims, see plan details, and update their contact information. Members benefit from the ease and accessibility of our interactive virtual system. For members who prefer to access via iPhone or Android, CareSource's mobile application demonstrates the next step in expanding health care access.[3] Our beneficiaries are empowered to manage their entire health profile in the palm of their hand.

[2] (The Center for Medicare & Medicaid Services, 2020)
[3] (CareSource, 2020)

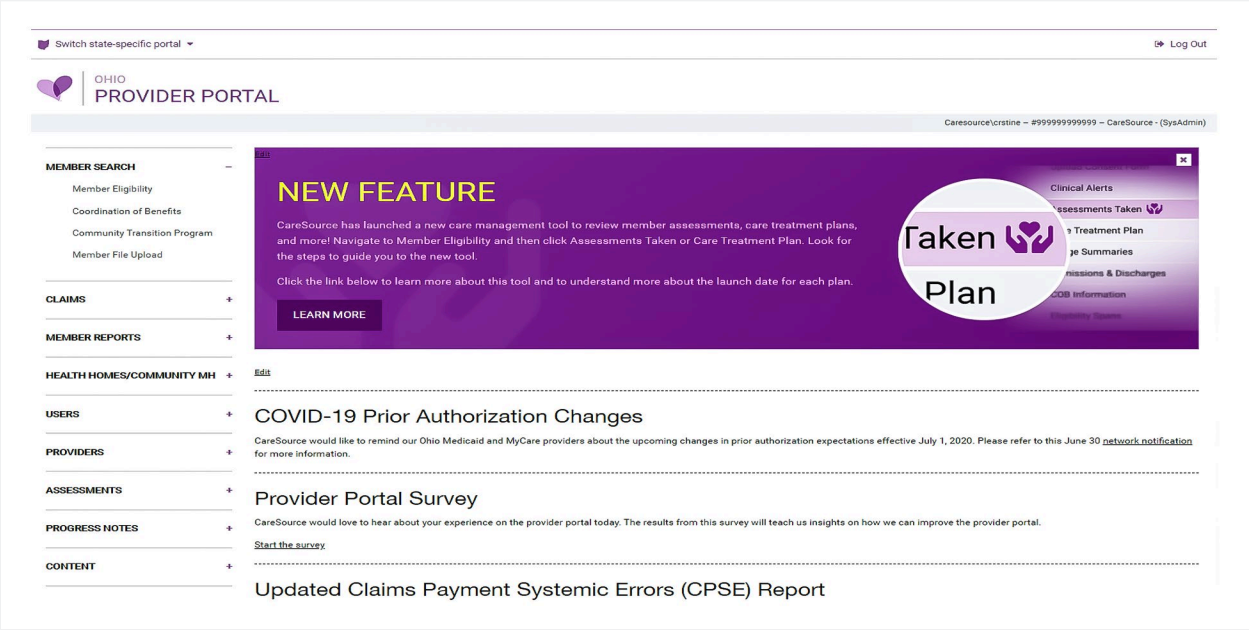
Member Portal



Through increasing investment in technology, CareSource is shifting the locus of power to members and providers as a key element of our Empowerment Model.

For any provider serving our members, we offer a provider portal that is a secure, encrypted online tool. Our providers can easily access critical information and execute online transactions at no cost. The service is free of charge and accessible from any computer, tablet, or smart phone without any additional software installations or plug-ins. The portal has speedy download times and providers can securely submit medical documentation for claims, disputes, and appeals up to 100MB. The portal sends receipt confirmation messages after providers submit documentation. Providers can also use the portal to check status on submissions and requests. The figure below is our provider portal home page.

Provider Portal



Improving health outcomes is a complex process that requires both state and member buy-in, and MCOs have become experts at navigating state resources while collaborating with their members to improve their quality of life. MCOs also offer budget predictability in times of uncertainty, value based purchasing from providers, care coordination expertise, and taking on the responsibility for improving member outcomes while reducing overall state Medicaid costs. CareSource's Integrated Care Management program is a biopsychosocial, interdisciplinary model that allows us to provide comprehensive support and empower all of our members, including our special populations, to self-maintain and manage their health and well-being. Our integrated care model addresses the physical, behavioral, and social needs of our members by providing services related to care coordination, referrals, advocacy, integrated behavioral health, and SDOH. CareSource believes that our experience and expertise enable us to provide valuable insight in areas related to member enrollment, special populations, member engagement, care coordination, integrated care, and SDOH that we believe would most benefit the state.

Managed Care Enrollees

How and when should OHCA transition ABD and other initially excluded individuals to managed care?

While CareSource is capable of providing services to all member cohorts including ABD upon initial program launch, we recommend that the Oklahoma Health Care Authority consider a phase-in approach for transitioning ABD and other initially excluded individuals into managed

care. Additionally, we suggest that the State initiate the transition by offering ABD and other special populations the ability to enroll voluntarily for a period of time, such as 90 days.

CareSource recommends that the Oklahoma Health Care Authority consider a phase-in approach for transitioning ABD and other initially excluded individuals into managed care.

Additionally, we suggest that the State initiate the transition by offering ABD and other special populations the ability to enroll voluntarily.

Our relationships with provider networks are strong and we have amassed hundreds of community based resources and collaborators. Our organizational and operations plans are proven effective in that we have implemented multiple program expansions and created health plan implementations that were “quiet,” with minimal impact to members, the State, and existing providers. Our belief is that a well thought out project plan results in a successful implementation and a smooth transition for members and providers. Across all our program implementations, CareSource has consistently met readiness review and implementation milestones in a timely manner.

We know a phased-in approach would allow OHCA to engage first with stakeholders, providers, potential members, and their families in program design and development as well as implementation planning. Stakeholders and advocacy groups have the best interests of their groups in mind and are familiar with their members’ needs and challenges. In addition, this will meet the CMS requirement regarding stakeholder input. Working with stakeholders and advocacy groups throughout the process will enable the State to address their concerns head-on and cultivate a partnership that will support the State during program transition and address any unforeseen complications. Additionally, collaborating with provider groups in the planning process, including establishing timelines for transition, helps maintain a network of providers that members are familiar with from the FFS program. Preserving a responsive and available provider network aligned with quality measures focused on outcomes with innovative payment methodologies ensures members and their families that their current care and service level will not change. Furthermore, having access to providers that members know and trust is critically important, especially among older high-risk, special needs populations.

CareSource recommends that OHCA work with managed care plans to offer care continuity and ensure that members have ample time to make plan selections by:

Requiring a fully contracted and credentialed network of rural, urban, and Indian Health Services providers upon contract award to ensure the MCOs have met access and network adequacy requirements as a function of their readiness prior to go live.

As OHCA considers its enrollment plan, we have provided three examples of state phase-in activities: Georgia, due to similar population health burdens; Oregon, with its similar geographic challenges; and New York, as an example for I/DD enrollment. We have also included best practices identified by the Center for Health Care Strategies (CHCS) based on an assessment of California's transition of its ABD population to managed care. **Below are examples from Georgia, Oregon, New York, and California that provide insight to coordinating care for complex individuals:**

Georgia: The State planned to implement a state plan amendment (SPA) to transition ABD members into its managed care Medical Coordination Program and enable the following groups to enroll into the program voluntarily:

- SSI, Public Laws, Institutionalized (nursing home, inpatient hospice, long term hospital, etc.)
- Home and Community Based Waiver, Deeming Waiver, and Medically Needy

Georgia's plan included phasing in ABD enrollment by making its Medical Coordination Program services available to ABD eligible enrollees in its FFS program as well as making ABD individuals in nursing homes eligible for voluntary enrollment. Before the scheduled transition, the State held statewide stakeholder focus groups, hosted two public hearings, conducted an online survey, and created a "My Opinion" mailbox to receive stakeholder feedback. It also met with its ABD, Children & Families, Provider Task Forces, as well as its Mental Health and Substance Abuse Workgroup to gain input on program design and development. The State committed to continued engagement with stakeholders and committees during implementation.[4] Although in this particular case Georgia was delayed in its transition due to receiving higher bids than what was budgeted, this should be considered as a methodology for transition to specialty plans.[5]

Oregon: The State added the ABD population to its managed care program in 1995 as part of managed care implementation phase 2 (one year after phase 1 was completed, which rolled in

[4] (Georgia Department of Community Health, 2013)
[5] (Georgia Department of Administrative Services, 2014)

one-third of the State's beneficiaries under managed care between 1976 and 1994). In response to concerns regarding managed care's ability to meet the specialized needs of the population, the State Medicaid agency separately monitored the impact on the ABD population. A study conducted by Connecticut's Office of Legislative Research (OLR) suggests that expansive safeguards largely contributed to Oregon's successful ABD transition, including:

- Requiring all full risk health plans to employ an exceptional need care coordinator (ENCC) for responding to the ABD population's needs.
- Creating an ombudsman office for managed care participants to address access, quality, or care limit concerns.
- Enabling participants to access the state's fair hearings process and client hotlines.[6]

New York: New York is currently phasing in the intellectual and developmental disabilities (I/DD) population to Medicaid managed care using a three-step approach over four years through an 1115 waiver. The State designed and implemented a care coordination pilot with a small and select group of I/DD providers. Deemed care coordination organizations (CCOs), the structure mirrors the health home model while tailored to I/DD enrollees' needs. The CCOs coordinate services across multiple providers, care delivery systems, and community based services and supports. They also develop and manage person-centered plans with members and their families and enhance accountability by focusing on outcomes and quality measures. Before waiver implementation, the State held regional forums, information sessions and webinars, and summits to educate individuals and families on the new program. The State also worked with stakeholders to develop a specialized toolkit for CCO case managers to use. Phase 2 will offer voluntary enrollment for members into specialized plans with the I/DD benefit, and phase 3 will transition them to mandatory enrollment by 2022.[7]

California: Based on research regarding California's ABD population's transition to managed care, the CHCS suggests:

- Balancing mandatory enrollment by providing individuals the ability to opt in.
- Offering ABD individuals extra time to enroll before making any auto assignments and encouraging continual consumer involvement during the enrollment process.
- Maintaining continuity of care. For example, when making auto assignments for members who did not select a plan, enrollment brokers in Massachusetts looked at the state's utilization analysis for ABD individuals to identify preexisting relations with all

[6] (Cohen, 2009)
[7] (ADvancing States, 2018)

provider types, including primary and specialty care. The brokers also considered providers who had expertise in serving specific disability groups.[8]

Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

CareSource has experience meeting the unique needs of complex populations and coordinating care and support through our unique community based model. Intentionally and decisively, we have developed the talent and capabilities necessary to serve these groups. We must demonstrate that we understand and care about our members before we can engage them and influence change. We subsequently tailor the frequency, intensity, and mode of member engagement to each individual based on their physical health, behavioral health, and social needs. Our model of care uniquely blends physical and behavioral health and life services needs to holistically support our members in leading a physically, mentally, and spiritually healthy life. This approach means congruently focusing on health and social determinant needs while promoting member self-management and personal fulfillment. In each of our programs, CareSource strives to remove barriers and help members achieve better health and quality of life through activation, empowerment, coaching, and access to quality health care and life services.

Our Integrated Care Management Program is member-driven, and our care managers and Life Coaches promote active member involvement, which includes their designated caregivers.

We understand that each specialty population has unique needs. Children and youth engaged in multiple state systems, such as foster care, and those with complex behavioral health needs can seamlessly enroll into traditional model Medicaid managed care plans. However, these children and their families or caregivers often receive fragmented or duplicative services and the system of care is inefficient. Cross-system collaboration is difficult to achieve because of the lack of data sharing and communication infrastructure and the inherent challenges of coordinating across multiple agencies and departments.

[8] (Cohen, 2009)

CareSource recommends including multisystem engaged children in managed care plans with a demonstrated experience in providing High Fidelity Wraparound services.

High Fidelity Wraparound (HFW) is a structured and team-based care coordination process that uses an evidence based, nationally recognized model, which incorporates working with families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy.

Thus, these populations require lower care coordinator case ratios compared to care coordinators for other health conditions. Additionally, youth with behavioral health conditions require more face-to-face encounters with service providers than simple telephone calls. MCOs with experience in managing special populations, such as CareSource, are well positioned to reduce fragmentation through coordinating care and working with families, providers, agencies, social services, and community organizations to ensure we meet member needs.

Concurrent Multisystem Engagement for High Fidelity Wraparound

Children currently interacting with at least two or more social/state systems should be eligible for this service to maintain stability, consistency, and access. CareSource is prepared to engage in defining and developing this approach in a consistent and transparent way.

At-Risk Youth

To ensure capacity and clear program focus, incremental to the criteria listed above, additional eligibility criteria of “at-risk” of out-of-home and institutional placement as determined by the special service systems should be included.

HFW improves outcomes, avoids placing children in foster care, prevents placement disruption for children in adoption and kinship guardian homes, and meets the mental health, substance use, and related social needs of at-risk children and their families/caregivers. Populations that could benefit from this intensive care coordination are those identified previously as well as those who experience:

Through Innovative Thinking and Collaboration…

We succeed in finding answers to complex challenges faced by members, providers, and the communities we serve.

- Multiple acute inpatient psychiatric hospitalizations (within a designated time frame)
- Significant utilization of behavioral health services (targeting the top 5-10% of behavioral health utilizers)
- Risk(s) of being removed from their natural family
- Significant histories of placement disruptions due to behavioral health needs
- An adverse event, such as attempted suicide
- A history of out of state placements for behavioral health conditions

To operationalize eligibility for intensive wraparound care coordination, it would be helpful for an independent reviewer to determine behavioral health needs, including conducting a functional assessment. Based on the experience and activities of the states described below, local family and children's councils or other provider groups could participate in the design of a local or statewide-centralized evaluation and referral process as well as in the development of assessments and toolkits. This would ensure that those who are most familiar with these members help drive their care to the most appropriate settings and supports.

We bring energy, expertise, and results to all markets.

Complex Behavioral Health Needs

Members with complex behavioral health needs and multiple system interactions have poor health outcomes due to the gaps in care and disconnections among health systems in combination with increased challenges associated with navigating multiple social/state systems and care facilities. CareSource uses HFW to coordinate the behavioral health needs for youth engaged in multiple social/state systems to ensure stability, consistency, and access for children. Populations that could benefit from this intensive care coordination are those identified previously as well as those who experience:

- A history of intensive (frequent and acute) behavioral health service use or frequent/intermittent/high-cost service crisis, emergency department, or inpatient services.
- A specific score on functional assessment based on valid assessment tool administered by an objective clinician. Examples include the Early Childhood Service Intensity

Instrument (ECSII), Child and Adolescent Service Intensity Instrument (CASII), Child and Adolescent Needs and Strengths (CANS), Center for Youth Wellness' Adverse Child Experiences Questionnaire (CYW ACE-Q) and Adverse Childhood Experiences (ACEs), CAGE for alcohol use, CAGE-AID adapted from the CAGE for drug use, Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences Tool (PRAPARE).

- A presenting problem that is inclusive of a specific, measurable range of diagnoses including child-specific thought, mood, and affective disorder.
- A history of involvement with criminal justice systems and related transition challenges.
- A history of a Serious Mental Illness (SMI) who require special consideration during care coordination planning and response development, especially during periods of crisis.

CareSource recommends that OHCA require specialty plan enrollment for individuals with SMI and I/DD. This strategy allows these groups to have a tailored entrance into managed care. To ensure access and provider capacity, we suggest that the State consider categorizing eligibility criteria for children and youth by delineating those with complex behavioral health needs and those with ongoing engagement in multiple state systems.

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This strategy allows these groups to have a tailored entrance into managed care. To ensure access and provider capacity, we suggest that the State consider categorizing eligibility criteria for children and youth by delineating those with complex behavioral health needs and those with ongoing engagement in multiple state systems.

Specialty plans with in-depth experience in working with these members possess tailored tools and assessments to identify needs.

American Indian/Alaskan Native

Although CareSource has the capability and experience necessary to serve specialty populations regardless of plan design, CareSource recommends that OHCA initially allow specialty plans to serve American Indian and Alaskan Native populations due to their sovereignty, unique cultural needs, and vast health disparities and social determinants of health barriers to care. As the AI/AN population is guaranteed health care services through Indian Health Services (IHS), managed care plans must establish relationships and coordinate care among this network of providers. Additionally, managed care plans need to understand and support the IHS efforts to improve their members' health outcomes. AI/AN communities across

the country are assuming autonomy and leadership in their health care services, including pursuing strategies ranging from managing individual hospitals and clinics, grassroots community programs, and health education to partnering with existing insurers and health service providers. In Oklahoma, the state has a history of working with AI/AN's to improve health services.[9] Similar to our strategy with individual members, CareSource understands that working with AI/ANs includes partnerships with tribal leaders, enabling them to pursue their vision for health care among their members.

Among all stakeholders, CareSource will actively promote healthy American Indian and Alaska Native people, communities, and cultures in ways that honor and protect the inherent sovereign rights of Tribes.

CareSource recommends that OHCA initially allow specialty plans to serve American Indian and Alaskan Native populations due to their sovereignty, unique cultural needs, vast health disparities, and social determinants of health barriers to care.

Health disparities for American Indians and Alaska Natives are clear. As the AI/AN population is guaranteed health care services through Indian Health Services (IHS), managed care plans must put the work in to establish long term meaningful relationships and strategic partnerships, increase access to a broad network of physical and behavioral health care providers, fully engage with IHS, and coordinate care and services to improve the overall health, well-being and quality of life of American Indians and Alaska Natives.

Managing care for AI/ANs also requires a deep understanding of members' historical needs and challenges, including SDOH, to ensure that outreach efforts and services are adequate, culturally appropriate, and drive meaningful outcomes. AI/ANs experience higher rates of substance use, mental health conditions, and accidental injuries compared to other Americans due to cultural barriers, high poverty rates, and geographic isolation.[10] Differences in patient and provider values and how they communicate those values are particularly salient for the AI/AN population, whose traditions and culture play a large part in their overall health.[11] CareSource understands that health care is holistic, and while we work with our members to address their physical and behavioral health needs, we also routinely connect them to community based support organizations such as food pantries, housing and housing supports, legal, employment, and disaster services through our *CareSource Life Services*® program. We also appreciate the

[9] (Oklahoma State Department of Health, 2020)
[10] (U.S. Department of Health and Human Services Office of Minority Health, 2018)
[11] (Wille, Kemp, Greenfield, & Walls, 2017)

need to ensure that our providers offer cultural competency and sensitivity in care, as mistrust is prevalent among AI/AN patients regarding their health care provider. In addition to supporting the various medical and psychosocial needs of the populations we serve, CareSource is committed to ensuring culturally competent and linguistically appropriate services. We invest in employee education and training regarding the SDOHs, health disparities, health inequities, and the importance of culturally appropriate care. Additionally, our care managers and social workers receive in-depth training in trauma informed care.

Specialty Plans

Based on the states' experiences and activities below, we recommend that the State allow specialty plans to serve certain populations. Specialty plans with in-depth experience in working with these members possess tailored tools and assessments to identify needs. They have the capacity to conduct intensive outreach to members and their families to gain valuable feedback and trust. The activities highlighted below are examples of how states are transitioning targeted high risked groups into managed care.

Effectively caring for all populations requires MCOs to re-envision their role in achieving improved population health. This approach includes supporting a diverse range of member needs resulting from multiple health and social determinant factors within multiple settings that are coordinated across the biopsychosocial continuum of integrated programs and services. To manage all populations successfully, MCOs must offer best practice solutions, forward-looking innovations, and evidence-informed models of care. They must also provide solutions that resonate in individual lives with lasting and meaningful impact. **Below are examples from New York and California that provide additional insight into strategies for transitioning special populations into managed care:**

New York: The State is transitioning individuals with I/DD into managed care via an 1115 waiver, using a phased-in approach. New York designed and implemented a care coordination pilot with a small and select group of I/DD providers and worked with the providers to design CCOs that follow the health home model while simultaneously meeting the needs of I/DD enrollees. The CCOs coordinate services across multiple providers, care delivery systems, and community based services and supports, develop and manage person-centered plans with members and their families, and enhance accountability by focusing on outcomes and quality measures. Prior to waiver implementation, the State conducted intensive stakeholder outreach and worked collaboratively to develop a specialized toolkit for the CCO case managers. Members will have the ability to initially voluntary enroll in specialized managed care plans with I/DD benefit and will be transitioned to mandatory enrollment by 2022.[12]

[12] (ADvancing States, 2018)

To facilitate an integrated approach, CareSource recommends that OHCA implement:

- Data sharing across all involved multistate systems, including historical claims to support continuity of care.
- Uniformed screening tools and technology platforms.
- Legal guidelines aligned across all systems that allow MCOs access to information, family members, school systems, providers, and foster families.

California: The State began transitioning its seniors and persons with disabilities population to managed care in 2011. Individuals with chronic illness, poor health status, mobility limitations, functional impairment, and cognitive impairment were found to have more negative experiences with access to care and the overall program transition than other members in this group. Recommendations developed from the State's experience include having health plans use administrative data and health risk assessments to identify and conduct outreach to these individuals prior to program transition. Additionally, plans should partner with community based organizations and clinics that already have preexisting relationships with these individuals.[13]

How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

An individual's health is a personal journey that is a culmination of experiences, cultural beliefs, genetics, social-economic status, and position in life. At CareSource, our 30 years of experience serving vulnerable populations has taught us that you must first build trust and demonstrate that you care about them, their life situation, and their families to engage individuals in their health care. We accomplish member engagement by fully integrating primary care, behavioral health care, and SDOH. Shifting Medicaid enrollees to the center of care requires an understanding of the population's characteristics and social determinants. To make a significant an impact on members' lives, MCOs must effectively engage and motivate members to complete high-value activities shown to improve their health outcomes and drive down costs. MCOs must leverage behavioral economics concepts to design engagement strategies to promote health behaviors and capitalize on individuals' biases to increase the likelihood of achieving desired health outcomes. For example, behavioral economic research suggests that individuals are more sensitive to immediate gratification than delayed feedback, therefore successful incentive programs should target current (not future) behaviors and offer rewards quickly following the completion of a desired task.[14]

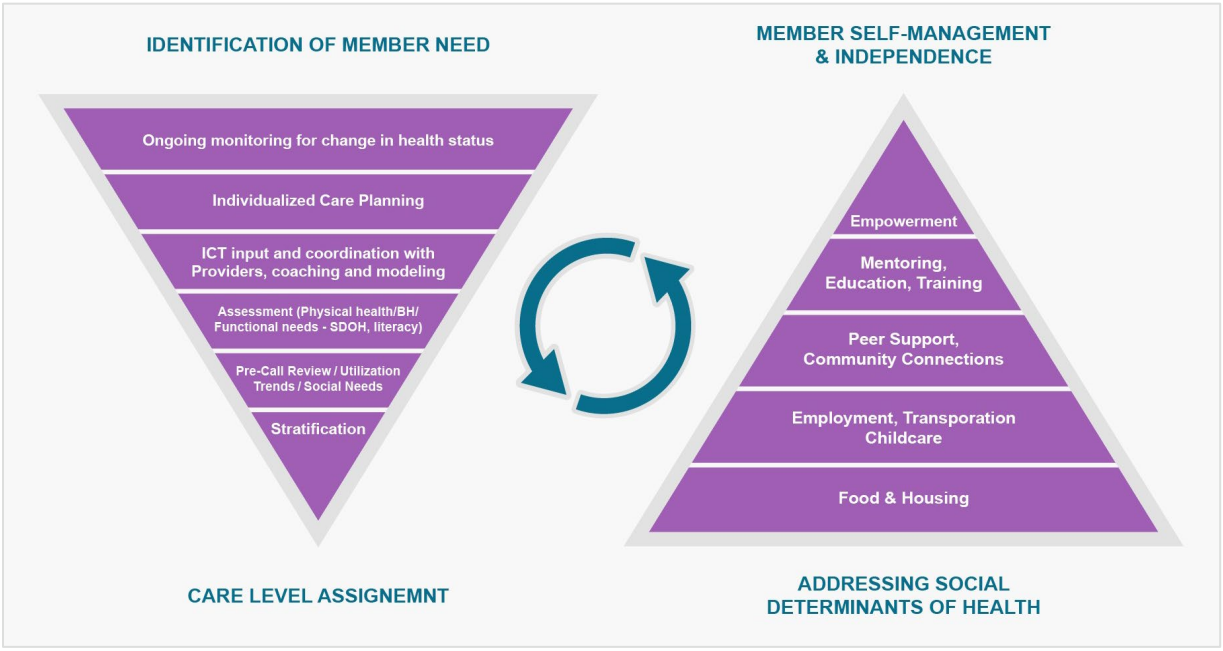
[13] (California Health Care Foundation, 2014)
[14] (NovuHealth, 2020)

Using social media platforms such as Facebook, Twitter, and Instagram to launch interventions targeting healthy behaviors is increasing in popularity and offers a practical, relevant, and cost-effective approach to engage and motivate members to participate actively in improving their health and well-being. Messages must target relevant populations and specific to behaviors requiring action. Tailoring messages to be more personally relevant influences behavior change and supports compliance with healthy behaviors.

CareSource Life Services® is the umbrella framework through which we address SDOH including hunger, housing, social stability, workforce development, and employment.

Based on Maslow's hierarchy of needs, CareSource has developed strong community partnerships, which help our life coaches and care managers work together to ensure our members have stable housing and access to food necessary for human survival. This is the foundation we build on to ensure our members have the security they need to focus on building the solid structure they need to begin addressing other life, health, and self-actualization needs. Within *CareSource Life Services®*, our *CareSource JobConnect™* program addresses the education and employment barriers that many of our members face and that impede their path to self-sufficiency. *CareSource JobConnect™* is widely recognized within the managed care industry for reducing dependence on governmental services by providing members with life coaching, access to community based resources, and support setting and reaching their professional and educational goals.

Empowerment Model



We know we cannot do it alone, so we build partnerships to address gaps in community resources. We have relationships with a wide variety of community and faith-based organizations across states in which we serve who provide transportation, connections to social, spiritual, and community activities, prepared and packaged food, housing assistance, legal aid, victim services, behavioral health services, and job supports. Locally based CareSource *Life Services*® and care management teams proactively engage with community organizations to exchange information about programs, services, and resources. These firmly established and mutually beneficial relationships allow us to work collaboratively with community partners to facilitate support and care for our members.

One of our most innovative programs, the Indiana Reentry Program, reflects our core values and mission. Upon execution of our Indiana contracts, CareSource recognized that members released from incarceration had significant medical, behavioral health, and social needs. We engaged with the Indiana Depart of Correction (IDOC) to create a program allowing CareSource to assess the needs of the individuals and support their reintegration into society. A dedicated reentry team, embedded in every IDOC prison, educates offenders prior to release through prerelease classes and seamlessly connects them to physical and behavioral health services as well as education, employment, and community supports. CareSource's work with returning citizens also aligned with the governor's commitment to better prepare offenders to re-enter society successfully.

CareSource recommends using three core member engagement strategies:

- Inclusion of family members and supports
- use of multiple communication modalities
- continuous outreach and communication

Establishing relationships and building trust with members is the first step to engaging them in their health care. MCOs and providers must strive to communicate effectively with each member, and, when appropriate, their families, through personalized communication rather than global messaging. Additionally, MCOs should use strategic incentives to encourage healthy behaviors such as smoking cessation. CareSource encourages members to utilize health services appropriately and engage in healthy behaviors. All members receive information on how they can start earning rewards in their enrollment welcome letter and new member kits. We also provide reminders about our rewards program on our website and member newsletters. Our customized incentive program encourages members to receive the care that is right for them. Members who complete specific health behavior activities receive a letter in the mail that congratulates them for achieving their goal and informs them that CareSource added the points to their rewards card. Using their rewards card points, members can purchase healthy items from participating retailers.

We reinforce our commitment to preventive services by offering rewards for completing healthy activities and routine checkups. *Babies First*® is our member incentive program focusing on pregnant members and their newborns and offers expecting parents' rewards for attending prenatal and postpartum appointments and well-baby visits up to 18 months. We developed the *Babies First*® program six years ago in response to feedback received during a Member Advisory Council meeting. We understand incentives are limited to no more than $150 per pregnancy. We will not extend incentives above these amounts without Ohio Department of Medicaid approval. Members must re-enroll in this program with each pregnancy to earn rewards.

We recognize that children, especially adolescents, are more reluctant to use preventive health services at a life stage when we want them to establish life-long healthy habits. Members can sign their kids up for a rewards program online by visiting CareSource.com or by calling Member Services. We issue rewards in the child's name if the child is enrolled as an independent CareSource member. Our Kids First Incentive Rewards Program offers children ages 18 months to 18 years to earn rewards for the following areas:

- Well-child visits
- Dental visits
- Age-appropriate vaccinations or flu shots
- Lead screening
- Follow up after an Attention-Deficit Hyperactivity Disorder (ADHD) visit

CareSource also offers a program to reward adult females for completing preventive screenings. Our Women First program is for females ages 19 and older and allows members to earn rewards by completing mammograms, Pap tests, routine dental and eye exams, an annual physical and flu shot, and more. Women can redeem their rewards for gift cards to numerous retailers including, Marshalls®, Home Goods® Panera Bread® and more. Members can sign up online or by calling Member Services.

We partner with the state and local communities to strengthen the health of our members by integrating their priorities with our programs and approaches to whole person care.

Regardless of how MCOs approach outreach and engagement activities, the member's preferred communication methods determine the appropriate strategy. Uniformly, MCOs engage with members through phone calls, face-to-face visits, personalized text messaging, and emails. As the use of technology such as mobile applications and social connection platforms has increased, MCOs have begun incorporating social media, televised campaigns, and constant

contact tools to drive population health educational messaging. Additional strategies for member outreach and engagement include:

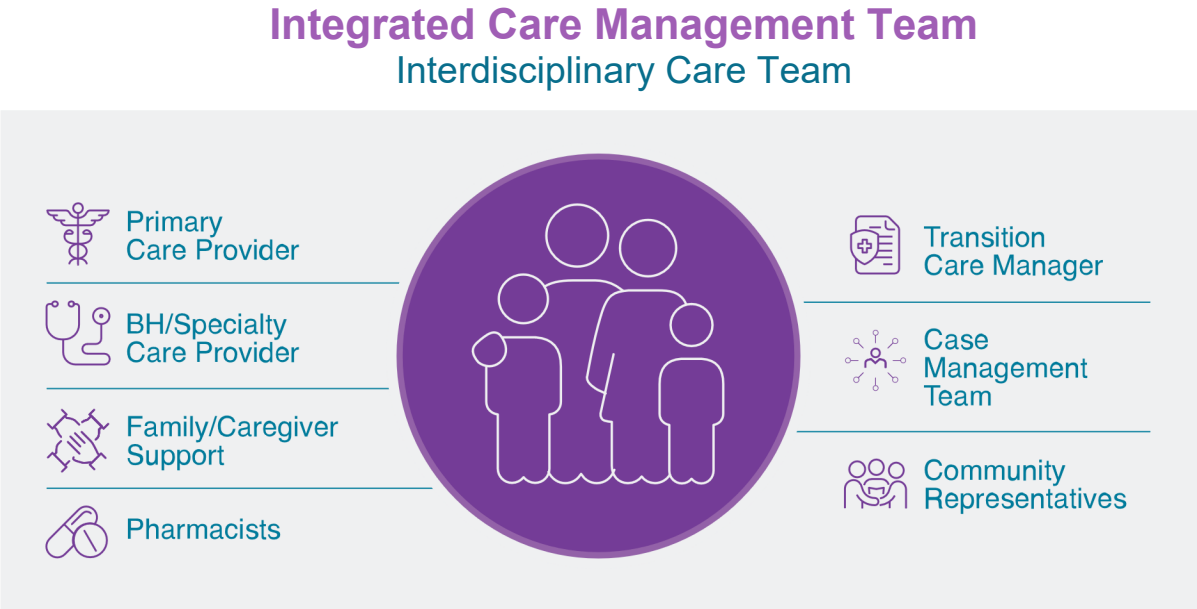
- Promoting benefits through the member handbook, welcome calls, member newsletter, call hold messaging, online messaging, text messaging, and email communication.
- Providing telemedicine and telehealth avenues of health care delivery which enable members to access much-needed services in areas where access is often limited.
- Participating in the various social media platforms that members regularly access to provide member education and important plan information as another vehicle to foster member choice.
- Offering value-added benefits such as enhanced transportation services which help members to apply for needed benefits, financial health services through banking institutions to offer fee-free services; member assistance funds to purchase emergent and essential infrequent needs to foster parents to assist with clothing, personal care items, bedding, car seats, etc. and others for critical needs such as utility bills, pest eradication, furniture, etc. which affect member safety and stability.
- Operating an accessible, easy to maneuver member portal, which provides on-demand access to information and mobile application self-management tools.
- Providing financial rewards and incentives that members value to promote ongoing participation. These serve as catalysts, which encourage members to self-manage their care.
- Engaging family members, caregivers, and significant others in the care planning process to support sustained change.
- Hosting educational opportunities in familiar locations such as schools, churches, or libraries provides opportunities to build relationships with members and educate them on wellness programs and activities.
- Creating relationships with community service agencies and partners who support members as they work toward reaching their wellness goals and maintaining successful outcomes.
- Hosting community events, such as job fairs, that assist members and nonmembers alike in finding and maintaining employment, which promote self-sufficiency.

Often, members want to improve their health but face significant challenges. Our engagement model seeks to identify and remove or reduce barriers to care and empower members to take charge of their health. MCOs must ensure that their efforts engage members and their families, align with state wellness programs as well as the coordination of services, and assist members in receiving all available benefits in order to improve the overall health, wellness, and quality of life of vulnerable populations.

Benefits Provided Through MCOs

What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

CareSource is a leader in providing care that fully integrates physical health, behavioral health, functional needs, and SDOH. We understand that mental and emotional well-being is essential to overall health. We offer a unique, high-touch, member-centric care management model with a fully integrated behavioral health approach that supports seamless access to needed services, improves health outcomes, and reduces costs. For our members experiencing behavioral health conditions, it is essential to their overall health and well-being that we engage them as early as possible.



Our Integrated Care Management program that enhances care coordination, facilitates access, and removes barriers to care. Using assessments and historical data, we place members into one of the four programmatic levels of care management to monitor changes in health status or needs. Our Integrated Care Management program connects members with a care team to develop an integrated care plan to address all their needs, and our Transition Care Manager assists members making transitions between care settings. We include behavioral health case management services within all aspects of our program. We train our staff members in behavioral health interventions, such as understanding mental illness and substance use disorders, motivational approaches to engagement, and accessing and providing resources for self-management and support services.

CareSource recommends integrating quality measures and data sharing to ensure providers and health plans have a holistic picture of members' physical and behavioral health diagnoses, referrals, utilization, and treatment plans. This enables providers to assess the gaps in care, better coordinate treatment, identify high-need and high-cost individuals, and create targeted quality strategies. CareSource also recommends utilizing payment structures and models to align provider financial incentives with integrated care delivery quality measures.

CareSource recommends integrating quality measures and data sharing to ensure providers and health plans have a holistic picture of members' physical and behavioral health diagnoses, referrals, utilization, and treatment plans.

This enables providers to assess the gaps in care, better coordinate treatment, identify high-need and high-cost individuals, and create targeted quality strategies.

Our strategy to improve the integration of services is built on these three foundational pillars:

- Member Empowerment: Empowering members begins with the thorough and routine assessment of behavioral and physical health status and need, SDOH barriers, and access to services. Through the identification, stratification, and acuity leveling process where data such as claims, encounters, and utilization pairs with health risk assessments, we apply both an analytics and clinical judgement process to inform levels of care management. Our Integrated Care Management team will promote member independence and personal choice in selecting the resource options and services. We use an empowerment model through our Integrated Care Management program to work to a member's strengths and provide education, supports, and resources to them and their caregivers. Within the health assessment, the member's perception regarding the influence they have over their own health care improves their ability to access services.

- Uniform Assessments: A uniform framework for member engagement across treatment providers and locations promotes integration and consistent non-duplicative approaches to care, as well as prescribes a consistent course of action based on the member's readiness for change. CareSource uses comprehensive, uniform assessment tools that support care planning and level of care decisions, facilitate quality improvement initiatives, and allow for the monitoring of outcomes. Providers must enter the CANS or Adult Needs and Strengths Assessment (ANSA) data for each member into the Data Assessment Registry for Mental Health and Addiction (DARMHA) System to establish level of care and eligibility for a Medicaid Rehabilitation Option (MRO) service package.

- Continuous Communication*:* Helping our members learn to manage their condition and succeed in recovery requires rigorous communication on our part with behavioral health

and non-behavioral health providers to coordinate services for our members. We have excellent relationships with Community Mental Health Centers (CHMCs) provide the necessary foundation for giving each member the individualized attention deserved to reach his or her potential.

Below is an example from New York that provides additional insight into strategies for improving integration of health services:

New York: The State offers a streamlined case management and comprehensive assessment. One major component of New York's transition of I/DD members to managed care is the use of electronic person-centered life plans that are shared among case managers, state agencies, providers, pharmacists, and community based organizations, and others. New York requires its CCOs to partner with regional health information networks for data sharing and exchange and to document the following:

- Desired quality of life, health, and functional outcomes
- Safeguard description and supports needed to reduce the likelihood of harm
- Employment status
- Services, including physical, behavioral health, and Home and Community Based Services (HCBS) long term services and supports
- Behavioral support needs
- Physical health conditions and treatment information
- Emergency plan[15]

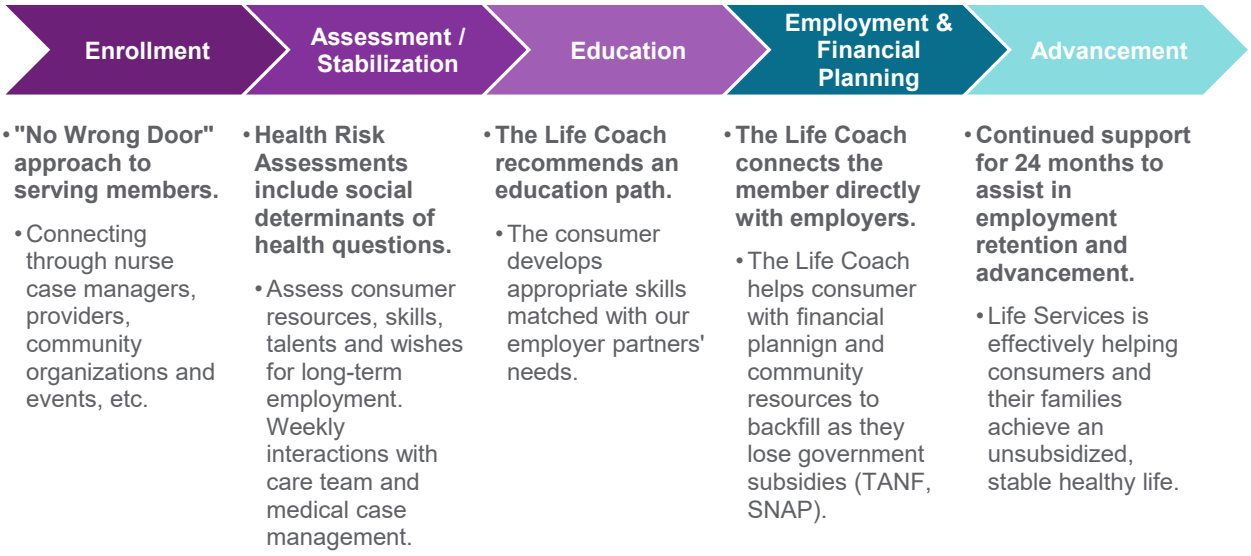
Populations with inherent vulnerabilities, such as comorbidities, limited natural supports, functional and cognitive limitations, and behavioral health conditions have more difficulty with self-maintenance (including adherence to medication regimens and keeping medical appointments) and life management skills (including paying bills timely and eating healthy). Limited support in addressing these challenges can lead to revolving cycles of episodic stability and relapse, greater risks for homelessness, exacerbation of secondary health conditions, and early mortality. Additionally, members who are involved in the child welfare system have experienced trauma and adverse childhood experiences, which require early and intensive interventions to promote resiliency and positive health and social outcomes. Children with serious emotional disturbance need early and intensive interventions to tap into their resiliency and put them on the best path toward a productive and healthy future.

[15] (ADvancing States, 2018)

Addressing SDOH in conjunction with physical and behavioral health is essential to the development of comprehensive and integrated care plans. Together, our Integrated Care Management program and *CareSource Life Services*® programs provide a holistic, member-centric approach to comprehensive care. Our programs are more than just care management programs. They constitute a revolutionary approach for how CareSource collaborates with our members and their support system to provide the following: education, wellness and prevention, care coordination, utilization management, disease management, and other community support services.

Medicaid member statistics underscore the criticality of a highly cohesive, coordinated, and integrated program of supports that holistically embraces and addresses the needs of Medicaid members. CareSource prepares for and invests in bringing holistic supports and solutions that will assist members with behavioral health conditions to attain and sustain recovery and reach new levels of independence and prosperity. We do this by coordinating care through the lens of improving member experience while managing utilization to focus on resources and supports that result in the best population health outcomes.

CareSource Life Services®
Member Pathway to Empowerment



How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance?

At CareSource, we know that SDOH are key drivers of health care access, utilization, and outcomes. As such, SDOHs require full integration into the treatment of members' physical

health. What sets us apart from traditional managed care is our record of accomplishments and results in integrating these nonclinical aspects into every interaction we have with our members. The CareSource mission is to make a lasting difference in members' lives by improving their health and well-being. This has catalyzed our commitment over the past five years to develop programs that target our members' social needs – nutrition, transportation, housing, jobs, social connectedness, communication, access, and more.

Our approach for facilitating referrals and tracking outcomes is centered in our *CareSource Life Services*® program, which is the umbrella framework through which we address SDOH including hunger, housing, social stability, workforce development, and employment. Members and nonmembers alike have access to this program. We identify members with SDOH needs in a variety of ways. If a member is in care management, the care manager can identify these needs through personal conversations, assessments, and provider communications. Members not in care management may also access these services. We identify these needs through member contacts with our Member Services staff, job fairs, mom-baby events, etc. We assign life coaches to members not in care management. Life coaches work with our members and nonmembers in the program for 24 months to ensure the necessary follow up and provide needed assistance that effects stability.

CareSource routinely connects members to community based support organizations such as food pantries, housing and housing supports, legal services, employment opportunities or skills training, and disaster services. Access to services includes ensuring that members receive services in a timely manner and the services provided are quality and meet their needs. A progressive approach to tracking referral services includes the collection and sharing of information across various programs (SNAP, TANF, childcare, etc.) to create a snapshot of the services a member receives.

We build diverse networks that contribute value and increase member access to care.

We continue to expand our community based network of services and supports through our Aunt Bertha and customer relations management software platforms that assist us with locating and tracking referrals. Additionally, our Life Services® team tracks SDOH referrals by entering the community resource referral and indicating which type of referral it is, e.g. housing, utility assistance, food, childcare, furniture, education, etc. into our Microsoft Dynamics CRM system. Life Coaches and care managers follow up through conversations with the member to find out if the member utilized the community resource and if so, was the outcome successful. Team members enter the outcome as "WON" or "LOST" and why the outcome was a win or loss. We can then run reports on how many referrals we made for each type of SDOH along with an explanation of the outcome.

At least 35 states already include the drivers of health in their contracts with MCOs, and other states have introduced standardized screening to identify social needs such as housing, food insecurity, transportation, and interpersonal violence. **Below are examples from North Carolina and Massachusetts that provide additional insight into standardization of key drivers of health:**

North Carolina: The state has a standardized fee schedule for health related social services that Medicaid could pay for under the state's Healthy Opportunities Pilots program. The program invests in health drivers including housing, transportation, and access to healthy foods for high-need Medicaid beneficiaries. The state must incorporate value based payments for pilot services, which will gradually link payments for new services to health outcomes.

Massachusetts: MassHealth Flexible Services Program pays for some social drivers of health for certain Medicaid beneficiaries enrolled in Accountable Care Organizations. Benefits include home-delivered meals, home modifications to improve safety, and household setup costs including first and last month's rent. Members receive benefits directly through qualified community based organizations. MassHealth requires ACOs to screen their members for certain health related social needs and to provide navigation support to connect members with services to address those needs.[16]

How could OHCA measure MCO performance on social risk factor mitigation strategies?

CareSource has experience with designing and implementing value based incentive programs to reward our providers for achieving certain health outcome-based quality goals. We are aware of where most initiatives fall short in obtaining optimal results. CareSource utilizes a standardized, integrated, system-wide process to collect social risk information and to identify members with nonmedical health risks. We collect social risk information through these assessments and build dashboards to visualize trends within our population and regional social risk factors.

CareSource recommends aligning financial incentives to support SDOH interventions.

Performance measure scores should be adjusted to account statistically for social risk factors to measure performance accurately.

CareSource understands that SDOH plays an important role and influences health outcomes. We are familiar with different social risk factor mitigation strategies and offer a diverse array of

[16] (Pereira-Chakka & Lambdin, 2020)

social support service programs to our members to help them overcome barriers to health. Some of the main examples of SDOH domains include:

- Socioeconomic status or position with regards to poverty, employment, food security, or housing stability
- Education status and language or level of literacy
- Health care access, such as proximity, insurance, or transportation
- Neighborhood or environment, including safety and access to healthy food choices
- Social and community context, such as racial or gender discrimination or incarceration

Population and individual health are inextricable from social risk factors, and in order to improve health outcomes, we must address SDOH. However, performance measurement and payment practices typically do not account for these factors. As a result, providers who disproportionately serve at-risk populations are less likely to benefit from value based payment strategies.

Additionally, OHCA should determine which social risk factors have the greatest influence on health care outcomes and choose an indicator that is empirically most important. Next, OHCA can evaluate MCO performance based on the effectiveness of their social risk factor mitigation programs by tracking closed-loop referrals moving beyond screening to systematic efforts to connect members to social supports. States are increasingly requiring plans to provide closed-loop referrals (i.e., to track what happens to someone referred to a social provider); to maintain up-to-date information on community based resources; and to integrate efforts to address SDOH into standard care management policies and practices.[17] For instance, OHCA could measure how many of the MCO's members transitioned from being unemployed to employed after receiving job support services. Another example is how many members transitioned into stable housing. OHCA can measure member enrollment in MCO social support service programs. There are also process-related quality measures that involve social risk factor mitigation. For example, members with social risk factors have poorer outcomes on the frequency of blood pressure screenings, body mass index checks, or diabetes checks. The impact of process-based initiatives to mitigate social risk factors are easy to measure.

After identifying members with social needs, we provide resource navigation services and continuously assess the effectiveness of these support services. Our clinical platform allows us to track the needs of our members at geographic, population, and individual levels. We stand

[17] (State Health and Value Strategies, 2019)

ready to assist OHCA in evaluating the effectiveness of social interventions by analyzing not only health outcomes and access but also cost and efficiency.

Systematic evaluation and greater use of real time SDOH data supports the development of targeted and evidence based interventions expanding the scope of SDOH interventions to both the population level and individual social needs. At the population level, MCOs can advance targeted, coordinated investments in local communities to design interventions to reduce health disparities by using social needs data. At the individual level, MCOs can advance whole person and family-centered approaches to care coordination and management. Key health metrics that MCOs should track among members receiving coordinated referral services to address social needs include maternal health, wellness checks, preventive care screenings, chronic care, and behavioral health measures.

CareSource recommends performance based auto assignments based on measures selected for their relevance to OHCA goals and the use of closed-loop referrals to send and receive information to and from community based organizations.

- Closed-loop referrals to ensure that MCOs track the outcomes of referrals that are made to community based organizations and provide additional help as necessary
- Building a strong network of community based organization and collaboration with providers
- Requiring contracts and data sharing with community based organizations

It is essential that MCOs identify and follow up with members and families that are high-risk or emerging risk to poor health outcomes due to significant social needs.

Below are examples from North Carolina and Pennsylvania that explicitly require MCOs to track and report on the outcome of referrals.

North Carolina: The State requires MCOs to use a community resource referral platform called NCCARE360.[18] The system will enable health and human service providers to send and receive secure electronic referrals, share client information.

Pennsylvania: MCOs must implement at least one rapid cycle quality improvement pilot program, implemented with community based organizations on improving health outcomes and addressing social determinants of health.[19]

[18] (Center for Health Care Strategies, Inc., 2019)
[19] (Center for Health Care Strategies, Inc., 2019)

Care Management and Coordination

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

Trained Care Teams

Dedicated, mission driven, highly skilled, and trained professionals serve our members.

Behavioral health services are often fragmented and not easily accessible to members, families, and providers, making behavioral health care coordination a much-needed service. Therefore, MCOs should integrate their case management models to include both behavioral health care, physical health care, and community based services. At CareSource, we provide an Integrated Care Management program in which all staff members receive training in behavioral health interventions, such as understanding mental illness and substance use disorders, motivational approaches to engagement, and accessing and providing resources for self-management and support services. Additionally, we employ behavioral health specialty case managers, who have service experience and training in behavioral health assessment, resources, and interventions, to provide direct care coordination services to members and families. They are available to consult with other case management team members, medical directors, and medical management staff and provide an interdisciplinary approach for members who have complex medical and behavioral health needs. We also employ Facility Liaisons, who partner with Community Mental Health Centers (CMHCs), hospitals, and community behavioral health providers. The liaisons facilitate and improve the care management programs of those providers by supplying the needed tools, data, resources, and access to all "outside" care that improves member and population health outcomes for those provider's populations.

Timely delivery of behavioral health services is critical and fully supported through the integration of behavioral health and primary care within our provider network, and we are committed to continuous improvement efforts to increase access for our members. Our care management strategies *CareSource24® Nurse Advice Line*, IT systems, and claims payment system address both the behavioral health and physical health needs of members. Our open benefit design removes barriers such as authorizations and referrals for traditional outpatient behavioral health services. Members can access behavioral health services – including mental health, psychiatric, substance abuse, and chemical dependency services – on a self-referral basis. A referral from the member's primary medical provider is not required. For psychiatric services, managed care members can self-refer to any provider licensed to provide psychiatric services within their scope of practice. For primary care providers who do not have an integrated behavioral health care delivery system, we provide the necessary care management

support to ensure coordination of information across a member's providers to bridge any integration gaps.

Integration is not simply a function of connections and communication between providers. We incorporate this philosophy into all our day-to-day administrative and operational functions to employ multiple strategies for success. Our care management strategies, self-management tools through MyStrength *CareSource24® Nurse Advice Line*, IT systems, health partner operational support, and claims payment system address both the physical health and behavioral health needs of members.

CareSource recommends that OHCA require MCOs to:

Provide an integrated behavioral health and physical health care management program using a trauma informed care approach.

Additionally, we have provided best practices from Virginia, Oregon, and Ohio below that OHCA should consider implementing. In summary, these include:

- Requiring MCOS to utilize telehealth to address provider shortages, transportation access challenges, and geographic limitations
- Establishing payment methodologies that reimburse plans based on the holistic provision of care
- Ensuring that billing codes accurately reflect the current services rendered by behavioral health providers to managed care recipients to gain a better understanding of needs and network sufficiency.

Below are examples from Virginia, Oregon, and Ohio that provide additional insight to coordinating care for complex individuals:

Virginia: The Department of Health and Human Services (HHS) reports that nearly 80 million Americans live in a mental health professional shortage area. In Virginia, telehealth is a critical component to incorporating mental health care into primary care. The State's integrated provider-payer system allows for more fluid data flow to support the department telehealth program. Virginia served over 150,000 beneficiaries with telehealth services since 2012 and has conducted studies that show videoconferencing can be successful in treating post-traumatic stress disorder and that treating mental health issues via telehealth can be effective when compared to face-to-face visits.[20] CareSource was an early adopter of telemedicine within the

[20] (Greenspun, Korba, & Kane, 2016)

managed care environment, and we continue to build out our capacity and services, including behavioral health services.

Oregon: The State is encouraging its coordinated care organizations to change how they pay for services and to create a whole person care model that integrates dental, mental, and behavioral health. CCOs are required to have community health-improvement plans and spend funds to address social needs and health disparities. The State implemented a regional behavioral health collaborative (RBHC) made up of CCOs, community mental health programs (CMHPs), local mental health authorities (LMHAs), local public health authorities (LPHAs), tribes, individuals with lived experience, and other key system partners.[21]

Ohio: The State recently launched its Behavioral Health Redesign program that seeks to rebuild Ohio's community behavioral health system capacity. It expanded Medicaid rebilling codes used by behavioral health providers to create a more accurate representation of the services provided.[22]

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

MCOs should require primary care clinicians to screen members for behavioral health needs. Appropriate primary care behavioral health screening tools should include:

- The Center for Youth Wellness' Adverse Child Experiences Questionnaire (CYW ACE-Q) and Adverse Childhood Experiences (ACEs)
- The Patient Health Questionnaire-9 (PHQ-9) for depression
- The Edinburgh Postnatal Depression Scale for Postpartum depression
- The Columbia Suicide Severity Rating Scale (C-SSRS) for suicide risk
- The Collaborative Assessment and Management of Suicidality for suicide risk
- The Generalized Anxiety Disorder (GAD-7) for anxiety
- The Alcohol Use Disorders Identification Test (AUDIT-C) for alcohol use
- The CAGE for alcohol use
- The CAGE-AID adapted from the CAGE for drug use

[21] (Oregon Health Authority, 2020)
[22] (Pereira-Chakka & Lambdin, 2020)

- The Drug Abuse Screening Test (DAST-10) for drugs, excluding alcohol or tobacco
- The Health Risk Assessment (HRA)

Appropriate social determinants screening tools include:

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences Tool (PRAPARE)
- The Accountable Health Communities' Health Related Social Needs Screening Tool (AHC-HRSN)

CareSource recommends that OHCA also consider using evidence based tools integrated into primary care EHRs and accessible to plans through the Health Information Exchanges (HIE). This would allow consistency in workflows for the primary care providers as well as the ability to track completion of screenings and assessments by the MCOs.

CareSource recommends that OHCA consider using evidence based tools integrated into primary care EHRs and accessible to plans through the Health Information Exchanges (HIE).

This would allow consistency in workflows for the primary care providers as well as the ability to track completion of screenings and assessments by the MCOs.

To improve the management and coordination of members with chronic or complex health conditions, health plans must first ensure that they immediately identify and evaluate level of care needs for these members upon plan enrollment in order to initiate appropriate care plans and address any urgent health concerns. CareSource achieves this through the combination of our comprehensive health assessment, risk stratification system, and utilization of health data, all of which allow us to assess members across multiple domains, including physical and mental health, functional, cognitive, and socioeconomic capacities. CareSource uses our integrated patient-centered care management platform assigns members to one of the following initial risk stratifications:

- Risk Unknown/ no-risk
- Low—Disease/Condition Management (Level I)
- Medium/ Rising Risk—Care Management (Level II)
- Complex Case Management (Member- and Provider-Focused and RCP) (Level III)
- Intensive Need—Rapid Response Complex Case Management (Level IV)

Once assigned, health plans must engage members in a disease management program that is designed according to evidence based clinical practice guidelines. Our Integrated Care Management disease management program includes the following elements:

- Educating the member at all stages on their disease or condition to facilitate self-management and improve their health literacy
- Promoting coordination of care by collaborating and communicating with providers and other health care resources to improve member outcomes
- Member empowerment and encouragement for active participation and adherence to interventions
- Fostering a positive relationship between the member and their ICT
- A focus on the entire population, including not only those diagnosed with the condition, but also undiagnosed individuals who are at high-risk or symptomatic
- Interventions for all phases of the disease (acute episodes, remissions, exacerbations, and maintenance)
- Identification of comorbidities
- Alignment of the disease management program with population health quality initiatives

Technology based solutions that reduce administrative burden for providers and improve members' access to care.

Telemedicine is becoming another critical element to effectively managing individuals with chronic and complex conditions. The Agency for Healthcare Research and Quality (AHRQ) determined that enough evidence supports telehealth efficacy in some circumstances, including communication, remote monitoring, counseling for patients with chronic conditions, and psychotherapy as a part of behavioral health.[23]

CareSource was an early adopter of telemedicine within the managed care environment. Our program has been improving member health by permitting two-way, real time interactive communication between members and physicians through interactive telecommunications such as smartphones, tablets, and personal computers. MYidealDOCTOR® helped us focus on the advancement and delivery of telemedicine services. MCOs can improve health outcomes for the

MYidealDOCTOR
Your direct link to a physician 24/7

[23] (U.S. Department of Health and Human Services, 2016)

most vulnerable and complex populations by quickly identifying members with complex needs, designing care plans appropriate for their risk levels, educating members on their conditions, and utilizing telemedicine to enhance the provider network.

CareSource recommends that the State and other agencies develop and implement consistent statewide resources and processes in partnership with the Alcohol, Drug Addiction, and Mental Health Services boards. To create an integrated continuum of crisis services, the State should establish:

- An integrated telephonic crisis and support line that provides seamless care of members between local and statewide suicide resources, managed care, provider based, and Alcohol, Drug Addiction and Mental Health Services supported crisis services.
- A statewide "bed-board" for crisis, inpatient, residential beds, and coordinated crisis response teams to support the crisis line (Georgia has demonstrated this model to be effective).
- An integrated community and outpatient behavioral health staff within emergency departments for mental health and substance use intakes and treatment initiation.
- Sobering centers that serve as community drop-off points and nonmedical intake centers for local mental health and drug and alcohol providers to divert individuals from acute settings and criminal justice entry.
- Respite utilization benefits easily accessible by members and their families.

What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Reducing barriers to care and improving coordination for special populations necessitates a multifaceted approach that includes tailored care coordination services, flexible benefit design and options for self-referral, data sharing, and collaboration with the appropriate social supports, services, and agencies. We provide care coordination through our Integrated Care Management program, which focuses on coordinating care for those with complex needs, facilitates access and removes barriers to care, considers the social determinants that impact care, manages chronic conditions, prevents illness, and promotes the health of our members. Through consideration of the unique requirements of our members' health and circumstances and prioritizing the complex needs of our members, we identify and refer the most vulnerable members to Integrated Care Management for additional care coordination services. Our Integrated Care Management case managers maintain the responsibility and continue to be the primary advocate in ensuring the member's well-being across multiple care settings. The

Integrated Care Management team engages our members to educate and assist with the identification of barriers and works to remove those barriers, where possible.

Managing care for AI/ANs also requires a deep understanding of members' historical needs and challenges, including SDOH, to ensure that outreach efforts and services are adequate, culturally appropriate, and drive meaningful outcomes. AI/ANs experience higher rates of substance use, mental health conditions, and accidental injuries compared to other Americans due to cultural barriers, high poverty rates, and geographic isolation.[24] Differences in patient and provider values and how they communicate those values are particularly salient for the AI/AN population, whose traditions and culture play a large part in their overall health.[25] We tailor and educate our staff in community based and culturally appropriate outreach methods, which include employment and training of local people, building inclusive networks where we can, and establishing out-of-network relationships. We recognize that understanding and including nontraditionally treatments and practices, building local capacity that allows for the integration and use of technology, and providing support to community based groups through our foundation is essential.

In addition to implementing a tailored coordination approach that includes member advocacy, the National Academy for State Health Policy (NASHP) identifies best practices for care coordination for children and youth with special health care needs (CYSHCN) served by managed care plans. These include:[26]

- Developing and implementing a standardized risk assessment and assignment process to create consistencies across MCOs.
- Requiring MCOs to establish data sharing agreements with community based providers and coordinate services.
- Requiring MCOs to assign a care coordinator for each child, establishing one point of contact for families.
- Encouraging provider collaboration to support the coordination of care, including sharing care plans to help families and providers coordinate care, instituting universal forms for referring children to supports and services to decrease administrative burden, and developing procedures for monitoring referrals through to completion and communicating results to the referring provider.
- Monitoring and assessing the impact of MCO care coordination programs through existing quality measures.

[24] (U.S. Department of Health and Human Services Office of Minority Health, 2018)
[25] (Wille, Kemp, Greenfield, & Walls, 2017)
[26] (Honsberger, Normile, Schwalberg, & VanLandeghem, 2018)

We understand that the timely delivery of behavioral health services is particularly critical for populations such as individuals with SMI. We address this need through our open benefit design, which removes requirements such as authorizations and referrals for traditional outpatient behavioral health services and enables members to obtain these services when needed most. Additionally, we encourage the use of the self-referral options for services, including mental health, psychiatric, substance abuse, and chemical dependency services. For nonintegrated primary care and behavioral health care delivery, we provide the necessary care management support to coordinate information among a member's providers to bridge any integration gaps. Our experience in meeting the needs of Medicaid members with complex behavioral health and medical needs – over 30 years across all markets – drives us to not only continuously look for ways to enhance and facilitate coordinated care across all service providers, but to improve our early identification of behavioral health and comorbid conditions to introduce interventions and minimize the impact of these diseases. **Below are examples from Arizona and Virginia that provide additional insight to coordinating care for complex individuals:**

Arizona: While the State aims to integrate physical and behavioral health care into a single managed care plan under an 1115 waiver, it currently requires MCOs that serve CYSHCN to meet with the State's Division of Developmental Disabilities monthly to review individuals who receive services from both programs to improve their coordination of care.[27]

Virginia: The MCOs' assessment process identifies services that members receive outside of the managed care system. Their care coordinators request permission from the members' families to contact the respective agencies and coordinate services. The MCOs must have "community relations liaisons" to network with community organizations and agencies that may accommodate members' needs.[28]

Each population faces its own challenges that stem from health care access, care management needs, and external factors such as having to receive services from multiple providers and agencies. MCOs are responsible for the outcomes of all members and must, therefore, tailor their care management services and benefit designs to meet the needs of their members. Additionally, health plans should encourage data sharing among providers to streamline coordination of care and work closely with all state agencies and services that are engaged in members' care.

[27] (Honsberger, Normile, Schwalberg, & VanLandeghem, 2018)
[28] (Honsberger, Normile, Schwalberg, & VanLandeghem, 2018)

Conclusion

The cornerstone of CareSource's efforts is our well-developed approach to caring for our members. Our Integrated Care Management program empowers members to take control of their health and their lives. CareSource provides care coordination to the entire spectrum of the population through our unique member-centric care model, which includes our unique *Life Services*® programs. At its core, our Integrated Care Management program remains grounded in the principles of population health, meaning we will meet the care planning needs of the entire member population, not only those of the sickest, most costly segment. The frequency, intensity, and mode of member contact is completely tailored to each member, based on where the member falls in the continuum, current health status, risk factors and stratification. Moreover, we address their significant social needs through our *Life Services*® framework. Two of our signature programs offered through *Life Services*® are *JobConnect™ and CareSource CaregiverConnect™*. More than just care management programs, they constitute a revolutionary approach for how CareSource collaborates with our members and their supports to provide education, wellness and prevention, care coordination, utilization management, disease management, and other community support services. Our programs are rooted in sophisticated data analytics and dynamic web-based technology, yet fundamentally local with geographically based care teams to support our members on their wellness path. We strive to empower our members and their chosen caregivers within their communities and provide the supports they need to achieve the quality of life they desire.

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CareSource
Health Care with Heart

August 17, 2020

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Phone: 405-522-7300
Procurement@okhca.org

Re: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design 80720200002

Dear Sir or Madam:

Thank you for the opportunity to provide input to the Oklahoma Health Care Authority as it gathers information related to its Planned Comprehensive Medicaid Management Care Implementation. CareSource has a long demonstrated history of working in partnership with State Medicaid Authorities to deliver managed care services to Medicaid beneficiaries. Within all of our markets, CareSource's programs, systems, and professionals administer services that meet and exceed your objectives to:

- Improve health outcomes for Oklahomans
- Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume
- Improve member satisfaction
- Contain costs through better coordinating services
- Increase cost predictability to the state

Our response to your request for information includes detailed recommendations and examples to support your decision making process. Our recommendations are based on our experience and insights into services and functions that we believe are critical to managed care programs. We are available to provide additional insight into our response and to respond to all questions.

Thank you again for this opportunity.

Sincerely,

Erhard Preitauer
President & CEO
Erhardt.Preitauer@CareSource.com
937.531.2455

LeadingAge™ Oklahoma

August 17, 2020

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Attention: Procurement

Re: SoonerCare Comprehensive Managed Care
80720200002

To whom it may concern:

LeadingAge Oklahoma represents not-for-profit providers of aging services across the continuum of care, including nursing homes, assisted living, adult day, ADvantage waiver, home health, hospice and PACE providers. We have serious concerns regarding the transition of the ABD programs to a privatized managed care model.

It is our hope that following the planned transition of Women and Children's programs that ample time, a minimum of three years, will be allowed in order to assess the financial status and health care implications of such a program. Then there would need to be consideration of this information to determine if it is feasible to transition to a privatized managed care model for the ABD population.

Because of the growing number of the 65+ population, it is critical that this have serious review prior to any transition.

Thank you for your consideration of these recommendations.

Mary Brinkley
Executive Director

CARE providers OKLAHOMA

August 12, 2020

The Honorable Kevin Corbett
Oklahoma Secretary of Health and CEO of the Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Secretary Corbett;

As Oklahoma's largest association of skilled nursing providers, Care Providers Oklahoma (CPO) commends the OHCA for recognizing the importance of the current exclusion in participation of the Aged, Blind and Disabled (ABD) population in the current RFP process for MCO's. Oklahomans eligible for SoonerCare as part of the ABD population are the state's most vulnerable and should not be considered into a managed care environment given the numerous needs based challenges such as lack of provider enrollment are studied, and, if necessary, addressed.

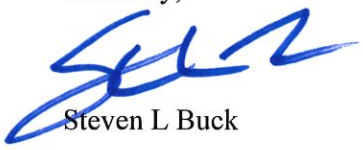
Specifically, CPO encourages the OHCA to permanently carve-out skilled nursing populations from any MCO effort. By nature, patients in skilled nursing settings are already in a bundled, fully capitated service array already. Introduction of managed care for this population would not result in additional savings for the state as these individuals are unlikely to benefit from behavior modifications due to illness, needs based placement decision, and aging progression. Furthermore, in the 2019 legislative session, law was enacted to create quality pay-for-performance incentives from providers through SB280, an important step in improving clinical outcomes. The implementation of managed care would only compromise existing care advancements gained by SB280 and could only generate savings for the state by reducing the current capitated rate by adding a middle man who would take a share of the current rate for administration and profit.

Comparing skilled nursing policy to other states, it is important to note that several states that have implemented managed care have chosen to exempt this segment of the ABD population from day one. Furthermore, states that did try to include the population in managed care have since reversed course. For example, in early 2020, the State of New York removed skilled nursing facilities from their managed care plan due to the points articulated above.

In the section on Managed Care enrollees, the OHCA discusses a 60-day window prior to disenrollment from managed care for patients transitioning into the fee-for-service model. The sixty-day period is excessive and should be shortened. Peer states have established more reasonable transition periods such as the first day of the following month when the admission occurs by the 15th and the first day next month when the admission occurs after the 15th. MCO's should accept and credential any willing currently licensed provider as part of the transition. Furthermore, the rate for the transition period should be equivalent to the FFS rate paid by SoonerCare for SNF facilities, care authorizations by the MCO should

be suspended for the transition period, and MCO's should be required to submit reimbursement to the facility within 10 days of submission of a valid invoice.

Sincerely,



Steven L Buck

President & CEO

Oklahoma State Senate

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standridge@oksenate.gov

Majority Whip

Chairman
Transportation Committee
Committees
Health and Human Services
Energy
Subcommittee HHS

Rob Standridge
DISTRICT 15

August 17, 2020

Mr. Kevin Corbett
CEO – OHCA
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Director Corbett,

I am writing this letter to let you know that after many years of study on this issue of capitated managed care, both within Oklahoma and around the country, I would advise you not to move forward with this plan.

The legislature, as well as practically every healthcare professional in the state, has consistently opposed outsourcing our Medicaid system to insurance companies because its supposed cost saving measures severely degrades the quality of care for our citizens on Medicaid. Not only did we see this in Oklahoma the last time this was attempted, resulting in multiple lawsuits, but even today in our neighboring states that have gone down this path. The results in managed care states have often been tragic. In Texas there have been many news stories laying out the problems with their move to capitated managed care, including an 8-part expose, *Pain & Profit* in the *Dallas Morning News*. Likewise in Kansas, many advocates for the vulnerable communities have expressed their frustration, some of which have been in the news, and the federal government discontinued their capitated managed care program at one time calling it a danger to those it was supposed to care for.

With regards to the costs of this program, Oklahoma, one of the least expensive Medicaid states in the nation and easily in the top five, has spent a little over $6,000 per recipient per year over the last five years. Whereas, in neighboring states where they outsource their Medicaid systems to these massive insurance companies, the costs continue to go up and up. In fact, if we were to adopt either of the financial models of the two neighboring states previously mentioned, Texas or Kansas, you will need to increase taxes on hard working Oklahoma taxpayers by 2 to 3 BILLION DOLLARS.

I find this irresponsible and uncaring of both our most fragile citizens that will be left with a Medicaid system far inferior than the one they have today, and our Oklahoma taxpayers. A massive increase in taxes, just so we can be like other states that seem to value the profits of large insurance companies over the hard-earned money of our constituents, is inexplicable and unjustified. In my eight years in the Senate, not one constituent has complained about Sooner Care and physicians in my district sing its praises. I beg you to reconsider bringing managed care into our great state. I am happy to visit with you about my in-depth analysis of managed care programs around the country.

Sincerely,

Rob Standridge

Rob Standridge

cc: Governor Kevin Stitt

DIAGNOSTIC LABORATORY OF OKLAHOMA®

DEMAND | SERVICE
ACCURACY
QUALITY
DLO

August 21, 2020

VIA U.S. MAIL & EMAIL

Oklahoma Health Care Authority
Managed Care Procurement RFI
4345 North Linden Boulevard
Oklahoma City, OK 73105
Procurement@okhca.org

Re: 80720200002 RFI – Diagnostic Laboratory of Oklahoma, L.L.C. Response

Diagnostic Laboratory of Oklahoma, L.L.C. (DLO) is a joint venture with Quest Diagnostics and INTEGRIS Health dedicated to providing innovative, timely and quality medical laboratory services to Oklahomans. We are proud to be a long-standing enrolled provider with the Oklahoma Health Care Authority (OKHCA) performing actionable diagnostic insights for Oklahomans enrolled in the SoonerCare Program. In 2019, we performed approximately 541,000 lab tests for Medicaid individuals through direct arrangements with over 3,500 physician client offices. Additionally, DLO serves over 150 hospitals within the Oklahoma healthcare community. We are grateful for the opportunity to share an interested stakeholder perspective as Oklahoma considers a comprehensive managed care approach for SoonerCare based on our collaborative relationship with OKHCA and our experience with Managed Medicaid delivery models.

As the leading provider of clinical laboratory and anatomic pathology testing located in Oklahoma and a joint venture with Quest Diagnostics, the largest laboratory in the United States, and INTEGRIS Health, the largest Oklahoma-owned health care system, DLO is a key player in the advancement of integrated healthcare across the continuum of care. Nationally DLO and Quest Diagnostics treat 30% of adult Americans annually and 50% over a 2-3-year period as we serve half of all physicians and hospitals across the country. Laboratory data is a primary driver for clinical decision support, treatment and therapeutic monitoring and serves as a catalyst to identify opportunities to achieve greater value in health, quality and cost outcomes. However, DLO is more than just a laboratory. Our diagnostic information services compliment and connect the transition of clinical care delivered across the spectrum of health care access points whether a community-based physician office, a Federally Qualified Health Center, an integrated health system or as a retail health encounter. With over 65 billion clinical lab results within our enterprise database, DLO's diagnostic insights reveal new avenues to identify and treat disease, inspire healthy behaviors and improve health care management. In the right hands and with the right context, our diagnostic insights can inspire actions that transform lives.

DLO is grateful to share input and suggestions with OKHCA based on our significant experience serving Oklahomans for their comprehensive medical and behavioral health diagnostic testing needs. Our perspective relates to several of the general topics noted in the RFI and we offer responses on the following:

- Managed Care Enrollees
- Care Management and Coordination
- Provider Payments and Services
- Network Adequacy

Managed Care Enrollees

Question:
How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

DLO Response:
A historic barrier for all State Medicaid Programs has been the ability to identify the clinical needs of its population and then link that population to appropriate healthcare services. As managed care arrangements have matured, MCOs that develop a deep relationship with a progressive laboratory partner (i.e. one with expansive test development, operational infrastructure and logistical scale; predictive analytics, and consumer-centric capabilities) experience demonstrable success with member engagement and improved health outcomes. At its core, testing is an intimate part of an individual's health journey, spanning from well and episodic care to chronic and acute illness. As such, laboratory data plays a significant role in quality and health improvement by identifying early disease through screening, fueling population health management efforts, supporting disease management programs, and customizing care through personalized medicine. Equally important is the ability of a laboratory partner to engage hard-to-reach individuals in the manner and locations in which they live and interact. Laboratories that bridge consumerism and testing capacity reach Medicaid individuals and improve health outcomes. In collaboration with our joint venture with Quest Diagnostics and INTEGRIS Health, DLO successfully reaches SoonerCare individuals to empower better health outcomes.

Identifying At-Risk Individuals
Laboratory data is essential in preventing, identifying, and monitoring chronic conditions including diabetes, cardiovascular disease, communicable infections, and thyroid disease for entire member populations. Using risk assessment and stratification tools, MCOs can lever laboratory clinical data for effective population health care coordination by identifying members who may require screening or other targeted health interventions and then close the gap in care. Lab data can be used equally for at-risk and pre-risk individuals. As opposed to claims data, laboratory data is real-time. Analysis may identify specific follow-up required so care coordinators can proactively reach out to providers and/or members to ensure appropriate and cost-effective actions are taken. For example, MCOs can track the percentage of diabetic members that are in good control, borderline control, and poor control and act to address members with inadequate diabetes control behaviors.

Difficulties in Accessing Care
Oftentimes Medicaid individuals experience enhanced transportation challenges that create barriers to accessing medical care. Clinical laboratory providers, like DLO, understand that ease of access is critical to patient engagement and improved health outcomes. At DLO we design our specimen collection operations to meet individuals where they are and engage. Further, we and our partners have a long history of focusing on consumer interests for a convenient and personalized experience that is relevant to the individual's specific needs. For example, Quest Diagnostics, was the first laboratory to offer on-line appointment scheduling and patient registration for specimen collection at community-based patient service centers. Individuals can now schedule convenient venipuncture 24/7 using a smartphone, computer or toll-free automatic phone system with automatic reminders. DLO couples the ease of appointment scheduling with convenient access locations within INTEGRIS

Health across the 77 counties. Within Oklahoma, DLO tackles transportation barriers using a robust infrastructure footprint that includes 45 patient services centers and 41 on-site phlebotomy sites within physician offices. In recent years, Quest Diagnostics pioneered collaborations with Wal-Mart and CVS Health to further extend access to where consumers engage. The right time and the right place empower individuals to schedule their lab tests in manner and location that is convenient for their lifestyles. The importance for community-based testing was brought to the forefront in the nationwide all-hands on deck response to the public health emergency. For its part, DLO and Quest Diagnostics rapidly scaled specimen collection operations for COVID-19 testing with Wal-Mart and CVS Health at drive-thrus and faith-based events.

Increasingly MCOs are partnering with laboratory providers to inform and complement strategies for risk assessment, population health and consumer engagement. The value a progressive laboratory partner brings extends beyond testing alone to innovative collaborations that improve consumer outreach and foster treatment adherence to drive health outcomes. Managed Medicaid RFPs should ask respondents for feedback on the scope and scale of their intended laboratory providers.

Care Management and Coordination

Question:
How should the State encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

DLO Response:
The extent and manner to which traditional utilization management tools, such as prior authorization and service frequency restrictions, are implemented should contemplate whether the performing provider has a direct or indirect relationship with the patient. OKHCA should require that MCOs adopt different utilization and cost-control mechanisms for testing performed at the patient point-of-care versus testing referenced to an independent laboratory as a mechanism to bring utilization back to its original policy focus - namely to - identify outliers in spending. Secondly, OKHCA should encourage MCOs to manage utilization through differential reimbursement levels that create disincentives for inappropriate test orders and recognize the wide range between low/high technology complexity. Currently MCOs grapple with legitimate overutilization concerns of lab testing using prior authorization and frequency restrictions, which ultimately foster excessive point-of-care services at the expense of appropriate reference testing. Lastly, OKHCA should encourage MCOs to adopt the American Medical Association (AMA) resources for best practices to identify true outliers in spending such as Gold-Carding whereby a healthcare provider who consistently adheres to evidence-based guidelines in its service offering is exempt from the payer's prior authorization requirements.

Utilization Management Options to Reduce Expenditures on Laboratory Testing
An increase in testing is not inherently an indicator of overdiagnosis by the ordering provider or program integrity by the performing laboratory. For example, molecular based testing using PCR/NAAT plays an important role in the detection and treatment of infectious diseases ranging from chronic viral to sexually transmitted with increased analytic sensitivity and specificity that allows for earlier intervention and improved patient outcomes. Professional medical societies, including the Infectious Disease Society of America (IDSA) and the U.S. Centers for Disease Control are migrating towards PCR/NAAT within their clinical guideline protocols. At the same time, Provider-Performed Microscopy Procedures (PPMP) is becoming less available as medical school curricula offer less focus on wet mount microscopy. We understand the need for OKHCA and MCOs to balance the scientific innovations from laboratory testing with stewardship to ensure fiscal responsibility and medically appropriate services.

While there is a need to balance and ensure appropriate testing, expenditures alone should not be an automatic trigger to impose utilization management levers for prior authorization; frequency limitations; and aggregate benefit caps. These traditional levers have proven successful to the extent there is a direct relationship between the patient and the performing provider of service. Generally, independent laboratories do not directly interact with patients but rather receive specimens that are collected by the treating providers. For independent laboratory providers, traditional utilization management tools are valueless administrative complexity. Conversely, tools that target potential program risk are far more effective to drive appropriate test use.

First, we suggest that OKHCA contemplate enhanced provider credentialing to root-out outlier test utilization for possible program integrity concerns both at the time of new enrollments and revalidation. This can be done via data requests from MCOs. Thereafter, provider price variation can be an effective tool to guide the appropriate use of the right test, at the right time, and in the right clinical setting. For example, separate fee schedules that align to National Correct Coding Initiative edits (e.g. CLIA waived modifiers) more closely reflect the direct patient relationship.

Secondly, the AMA's recommendation to exempt a provider, who adopts medically appropriate utilization standards as evidenced by prior claim data, from prior authorization requires under a 'Gold-Card' is gaining widespread attention. Within the laboratory provider context, if your test panels are consistently guideline driven and promote the right test at the right time, in the right setting, the lab earns a 'Gold-Card' and can perform testing as a trusted provider without a prior authorization. Auditing utilization is a core element of maintaining Gold-Card status to ensure that both the trusted provider and the payer are aligned.

Care Management and Coordination

Question:
How can MCOs improve the management and coordination for members with chronic or complex health conditions?

DLO Response:
MCOs are increasingly embracing precision medicine to guide population health to coordinate care for individuals with chronic or complex health needs. Lab tests and lab data are important components of precision medicine and population health in informing MCOs on how to clinically manage chronic and complex health conditions. Advanced molecular diagnostics coupled with predictive analytics help identify high-risk individuals to close gaps-in-care. A defined benefit for select advanced diagnostic testing to intervene earlier in an individual's health journey can assist OKHCA to achieve its population health objectives for: maternal health and infant mortality; and improved reproductive health to prevent cancer, HIV transmission and adverse perinatal outcomes. OKHCA should adopt a defined benefit for certain advanced diagnostics that MCOs must offer. We describe the issue and offer suggestions on the benefit design below.

Maternal Health & Infant Mortality
The lack of appropriate prenatal care contributes significantly to prematurity, low birthweight, and infant mortality. In addition, inconsistent adherence to clinical recommendations for prenatal care increases the disparity in perinatal outcomes. Laboratory testing is a major component of effective prenatal care as clinical results provide valuable diagnostic indicators of maternal risk or chromosomal complications with a baby. DLO is encouraged that key national medical stakeholders are exploring defined prenatal laboratory panels spanning the entire pregnancy as a value-based arrangement to improve maternal and infant outcomes. OKHCA could pioneer a maternal lab benefit that includes genetic testing that supports its population health targets. Examples may

include cell-free aneuploidy screening. As a value-based arrangement, the defined prenatal lab benefit could be accessible to all pregnant individuals. In a population that included pregnant women at average risk or high risk of fetal aneuploidy, QNatal Advanced offered by Quest Diagnostics, provided highly accurate discrimination between affected and unaffected pregnancies.[1] Testing within the prenatal panel would not be subject to prior authorization or non-covered service determinations.

Throughout the United States there is a dramatic increase in maternal opioid use and neo-natal abstinence syndrome. A defined lab test panel for newly pregnant individuals can help identify at risk populations and facilitate recovery services. OKHCA could determine the scope of presumptive and definitive testing and alignment to Oklahoma's treatment initiatives.

Reproductive Health and Family Planning

While STDs are largely preventable, they remain a significant public health problem in the United States and cause many complications such as reproductive health problems, fetal and perinatal health problems, cancer and facilitation of sexual transmission of HIV. The Centers for Disease Control reports that the incidence of STD has risen significantly since 2013 and there are approximately 20 million new STD infections each year. It is well established that laboratory testing can effectively detect and prevent STDs. Testing for these infectious diseases are generally considered covered services among payers (Traditional Medicaid, Managed Medicaid health plans and commercial payers). An 8-year retrospective study, using CDC data and Quest Diagnostics clinical data, found that the detection rate of hepatitis C virus (HepC) among women of reproductive age increased and presents risk as HCV infection is transmissible from mothers to infants.[2] Under the Medicaid program, testing for STD constitutes family planning services as a freedom of choice right.[3] Over recent years, CMS has issued various guidance reminders related to family planning, which acknowledges the diagnostic testing within the scope of the mandated benefit.[4] MCOs are generally silent in acknowledging laboratory tests as family planning services and adjudicate claims for chlamydia, gonorrhea and Hep-C based against contracted network status as well as coverage limitations. Further, MCOs broadly conclude that chlamydia testing using PCR/NAAT technology to detect microbial pathogens is experimental without considering the family planning nature of the test. OKHCA should consider targeting the diagnostic testing aspect of family planning to promote screening for STDs as a population health measure. OKHCA should also consider monitoring MCOs for compliance with family planning as it relates to diagnostic testing.

Provider Payments and Services

Question:

What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

DLO Response:

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[1] Guy C, Haji-Sheikhi F, Rowland CM, et al. Prenatal cell-free DNA screening for fetal aneuploidy in pregnant women at average or high risk: Results from a large US clinical laboratory. Mol Genet Genomic Med. 2019;7:e545 https://onlinelibrary.wiley.com/doi/full/10.1002/mgg3.545

[2] https://annals.org/aim/article-abstract/2625387/hepatitis-c-virus-infection-among-reproductive-aged-women-children-united

[3] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf

Several states beyond Oklahoma are evaluating MCOs for a comprehensive Managed Medicaid procurement. Feedback gathered from provider stakeholders revealed common themes for improvement in MCO provider service functions, including:

- Reduce administrative burdens related to claims processing and payment;
- Standardize prior authorization and other administrative functions; and
- Increase transparency and support accurate data sharing.

These themes are particularly important for laboratory providers. Inconsistencies among MCOs in medical necessity determinations, prior authorization and claims adjudication denial responses leave independent laboratories to navigate their network participation in the dark. There should be a single standard for medical policies, claim remittance remarks and appeals for covered SoonerCare laboratory services across all MCOs, irrespective of the delivery model.

Historically, lab testing was a Medicaid covered service generally without limitation. The advancement in laboratory medicine over recent years, especially as it relates to molecular genetic testing, led to a surge in new current procedural terminology (CPT) codes issued by the AMA each year; however, the development of medical coverage policies for laboratory testing has lagged especially among Traditional Medicaid programs and MCOs. For example, individuals, the ordering healthcare provider and the performing laboratory do not have standard information as to whether a specific CPT Code is always considered non-covered not versus medically necessary under certain situations (i.e. specified diagnosis). Nonetheless there has been a sharp increase in claim denials, oftentimes with a miscellaneous remittance remark code that do not convey the underlying rationale for the denial. Further, MCO provider appeal forms typically necessitate underlying medical records that are maintained by the treating healthcare provider and not the performing laboratory. Given the large volume of testing being ordered for Managed Medicaid individuals, the lack of medical policies for lab testing and appeal forms that disadvantage indirect healthcare providers such as laboratories, it is challenging for laboratory providers to effectively engage in a MCO appeal process. There is also a perception that appealing denials will negatively impact a laboratory provider's continued network status as the competitive nature of the diagnostic services industry is levered as a network development strategy.

Suggestions for Standardization and Transparency in Claim Denial Remittances

OKHCA should identify the scope of ANSI Remark Codes that can be used with laboratory providers to encourage transparency in claim denials and support provider-initiated appeals. Generally, there is both inconsistency and wide variation in the ANSI remark codes that MCOs utilize when denying laboratory claims, especially those for genetic testing. This causes confusion to laboratory billing operations and impedes filing reconsideration requests (aka appeals). Oftentimes MCOs respond back with a remittance advice risk code that is unspecified and suggests that the claim cannot be appealed. A common example is: Reason Code CO97 with the description: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." The prevalence of this Reason Code when more informative ANSI Codes are available questions whether its use is set up as a default to deter appeals for services where there is a lack of medical policies advising when one lab CPT Code is included in another lab CPT Code. Lastly, we suggest that OKHCA should allow laboratories to file complaints concerning systemic concerns with MCO Remark Codes and monitor MCOs on this metric.

Suggestions for Transparency in Non-Covered Services

Secondly, MCOs should disclose those CPT Codes (that appear on the Oklahoma Medicaid Fee Schedule) which they consider to be Non-Covered Services. Transparency further requires that Non-Covered Services be sub-categorized as either: 1) "never covered" –a service that is always outside the Medicaid benefit; or 2) "situational

coverage" – a service that is covered with a specified diagnosis code and/or is subject to frequency limitation. There should be published medical policies for CPT Codes identified as "situational coverage" that educate the individual, treating healthcare provider and performing laboratory as to when a specified diagnostic test is considered medically necessary. Further if OKHCA develops a medical coverage policy around a segment of diagnostic procedures, a MCO should not be allowed to implement a more restrictive medical and/or claims reimbursement policy. Real change will only come if there is communication of utilization parameters to all interested stakeholders, namely Medicaid individuals and more importantly the treating healthcare provider who orders the laboratory test. Lastly, we suggest that OKHCA consider whether MCOs should be permitted to deny lab claims for medical necessity when there is no published coverage policy that communicates the scope of benefit to individuals, the ordering healthcare provider and/or the performing laboratory. In its current state, laboratory providers bear the sole financial consequence, which ultimately drives up healthcare costs, for the MCOs' lack of benefit coverage transparency.

Suggestions for Handling Specimens Ordered for Non-Covered Services

As a final suggestion we ask that OKHCA consider issuing guidance to address a delivery system process flow gap uniquely impacting laboratories that fulfill orders from treating healthcare providers. Laboratories (excluding physician office labs) oftentimes find themselves in receipt of patient specimens that were drawn by the treating healthcare provider in the office setting and then sent by courier for testing. There is a critical need to confirm the permissive activity for laboratory as it relates to handling specimens that are received from healthcare providers either: 1) without a required prior authorization; or 2) for CPT Codes that constitute a Non-Covered Service. Florida recently promulgated regulations on permissible options when dealing with non-covered services for Medicaid individuals[5]. We submit that a best-in-class regulatory instruction would contemplate the predicament for indirect healthcare providers. For laboratories, the instruction could detail permissive activity in the pre-collection and post-collection scenarios such as:

Pre-specimen Collection Scenario

The treating provider attempts to order test where the billable CPT Code is identified as either: 1) requiring a prior authorization; or 2) a Non-Covered Service:

- Test order is blocked from processing in the lab's electronic order system (either at the treating provider's office or at a patient service center)
- Patient is informed of the prior-authorization requirement or that the service is determined non-covered under Medicaid
- Patient is offered an option to consent to financial responsibility and payment initiated at the time of service
- If patient declines the offer, the test order is not placed

Post-specimen Collection Scenario

The treating provider collects a patient's specimen and submits an order for a test where the billable CPT Code is identified as either: 1) requiring a prior authorization or 2) identified as a Non-Covered Service:

- Lab declines to perform test and advises the ordering healthcare provider
- Ordering healthcare provider accountability (e.g. report experience to MCO or State)

Suggestions for Evaluating Lab Service Provider Appeal Process

[5] 59G-1.050 http://flrules.elaws.us/fac/59g-1.050

Typically, MCOs appeal processes for laboratory testing is impeded by a lack of transparency and uniformity about what constitutes covered services and the root cause when a claim is denied. As OKHCA seeks information on MCO appeal processes under an RFP, we suggest that the laboratory provider situation be closely examined despite what we suspect will be the typical MCO response of minimal grievances and provider appeals for diagnostic testing. A more predictive measure to evaluate the transparency of a MCO on its laboratory coverage benefit would be to compare the MCOs number of denials for lab testing and analyze any inconsistency in patterns for provider-initiated appeals from other provider types.

As OKHCA considers its own RFP, DLO remains committed to be serving as a trusted SoonerCare provider to improve health outcomes, under whichever delivery model that the Department of Health determines most appropriate for Oklahomans. As it relates to a comprehensive Medicaid Managed Care model, DLO concurs with the provider feedback emerging from stakeholder activity in Ohio and Nevada. Specifically there is confusion caused when MCOs operate under their own policies which differ among MCOs and even from the Traditional State program. Further, the Massachusetts Health Policy Commission likewise recommended greater standardization of common administrative tasks across payers to identify and reduce drivers of valueless administrative complexity. Some states are now considering a fiscal intermediary to serve as a single point of entry for all provider claims and prior authorizations to eliminate redundancies. As OKHCA considers the future model for SoonerCare, DLO requests thoughtful consideration for the unique framework for diagnostic testing.

Provider Payments and Services

Question:
How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

DLO Response:
DLO strongly supports uniformity of prior authorization requirements as a meaningful way to make it easier for laboratory providers submit claims and resolve billing issues in a managed care environment. The new CMS reimbursement model for laboratory providers necessitates that labs become more efficient in its administrative costs. Eliminating variation in the applicability and implementation of prior authorizations would greatly help laboratories to ensure that high quality services continue to be accessible for Oklahomans. The American Clinical Laboratory Association (ACLA) examined the patient care risk associated with prior authorization for lab testing and developed tenets for payers to consider. ACLA's analysis may be informative to OKHCA as it considers this topic.[6]

From our perspective, DLO is supportive of OKHCA determining the universe of tests that can be subject to prior authorization requirements to prevailing model in most States whereby the scope of lab testing requiring a prior authorization is inconsistent among MCOs and further opaque to the performing laboratory. More importantly, while the healthcare provider ordering the lab testing must secure the prior authorization based on the underlying medical record, there is no consequence to ordering provider for failure to do so. Rather the performing laboratory bears the financial consequence when the service is denied for lack of a prior authorization. Given that Medicaid individuals cannot be billed for such denials, there is no incentive for treating providers to make sure that a prior authorization is in place before sending a patient specimen to a laboratory for testing. This disincentive is exacerbated when there is variation in the prior authorization process and scope from one MCO to another.

[6] https://www.acla.com/wp-content/uploads/2018/05/ACLA-Prior-Authorization-Tenets.pdf

For the reasons above, DLO believes that advanced diagnostics are good candidates for a State determined formulary for lab tests subject to prior authorizations, especially around: Prenatal Genetics; Cancer Diagnostics; and Pharmacogenomics; however, if a State determined formulary is not implemented, we submit that MCOs should disclose all lab tests (at the CPT level) requiring a prior authorization to OKHCA (referred to as "PA Lab Services"). MCOs should then publish the PA Lab Services on their website in a manner that is transparent to: ordering providers (network and non-network), performing laboratories and individuals. MCOs should further submit reports on PA Lab Services at the CPT level to OKHCA. The reporting period will be consistent with other quality measures and will disclose the number of prior authorizations at each CPT level: requested, denied and granted.

Beyond considering improvements to the scope of services subject to a prior authorization, uniformity in the data being requested and the request timeliness is equally important to evaluate and seek improvements. Similarly in the spirit of uniformity and transparency, we believe that OKHCA should determine the prior authorization form. As it relates to lab testing, prior authorization data request should be limited to information that is not otherwise available on an ANSI837 claim form.

Data Examples available within the ANSI837 dataset:

- Referring provider
- Diagnosis Code

Data Examples outside ANSI837 dataset:

- Prior Testing Received
- Family History

As discussed above, laboratories can (and often do) receive specimens without a prior authorization. The integrity of a blood/fluid/tissue specimen is placed at risk during the time the labs secure a prior authorization without performing the test. When an ordering provider fails to obtain an authorization prior to the specimen collection, a grace period should be available to the performing lab to secure the missing authorization after the testing is completed. We are aware that some Medicaid programs, such as Pennsylvania, grant authorization to laboratories for specimens received without a prior authorization after testing is performed.

Network Adequacy

Question:
What are reasonable time and distance standards in Oklahoma by provider type?

DLO Response:
MCO network development for laboratory provider differs from other provider types. The industry is highly fragmented and competitive, with thousands of independent labs, physician office labs, and hospital- based labs. Escalating expenditures for diagnostic testing along with spikes in utilization, especially around PCR/NAAT and toxicology testing coupled with a new reimbursement model arising from the Protecting Access to Medicare Act of 2014 resulted in provider network development that centered on a limited number of full-service laboratories versus boutique labs specializing in one testing segment. However, lab providers are not identical. Scientific innovation, testing capacity, specimen collection scale and reporting clinical results to payers and public health authorities are meaningful differentiators and should be evaluated in RFP network access questions.

It is critical that providers and MCOs put greater focus on ensuring that its laboratory providers have testing capacity to perform high-quality, responsible, and medically appropriate levels of testing. Our current and sustained national public health emergency has revealed the adverse consequences that preferred provider contracting can have for accessing timely screenings and diagnostic tests with clinical laboratories, made even more challenging for MCO individuals where their plan has sole source provider contracts. First, we propose that Medicaid enrolled labs be deemed essential providers by OKHCA. Second, we propose that OKHCA introduce laboratory-specific network adequacy standards to state and MCO monitoring activities.

While we support designating network providers as having preferred status for achieving high quality performance in service delivery and cost efficiencies, we believe sole source laboratory contracting risks countering quality goals and could lead to substandard care. While DLO's specimen collection operations are designed to maximize beneficiary access to care, additional factors may limit lab access beyond service center locations for any lab partner, including testing result turnaround times when there is a surge in demand for testing as we have experienced with COVID-19. This is because current lab capacity (and resources including diagnostic facilities, equipment, and staffing), is based on in-network contract enrollment and utilization.

Laboratory-specific network adequacy standards

Medicaid managed care programs have historically not set network capacity minimum standards to monitor laboratory service access. DLO advocates that OKHCA set and follow minimum network standards for clinical laboratory providers to assure that beneficiaries have dependable access to specimen collection sites, timely test results, and to timely treatment. Recent events with COVID-19 underscore the essential role labs play to assess health and initiate medical care. We propose six measures in the below Table to monitor clinical testing capacity of laboratory providers.

Table: Proposed Clinical Laboratory Network Measures

No.	Domain	Measure	Rationale
1	Access	Capacity	Measurement of lab testing capacity within performance benchmarks including: 1) specimen collection access; 2) transport of specimen; 3) testing of specimen; 4) timeliness of sending test results
2	Access	Appointment timeliness	Relevant when lab offers appointment time slots
3	Access	In-office wait time	In-office wait time for walk-ins and for prescheduled appointments
4	Service Use	Testing Volume	Lab testing volume against capacity
5	Capacity	Contingency capacity	Backup capacity during demand surge *or* % of increased capacity gained by extending testing and specimen processing shifts
6	Service Use	Service rates	Testing rates per 1,000 member months to monitor utilization against benchmark

In closing, DLO applauds OKHCA for seeking input from provider stakeholders as it considers a comprehensive managed care implementation for SoonerCare. As a joint venture with the largest nationwide diagnostics provider and the largest Oklahoma-owned health care system, DLO is a local laboratory with national access and scale. Laboratory testing informs approximately 70% of all medical decisions using real-time data and insights critical to

treat individuals with disease onset, chronic conditions, and for supporting a rapid response to manage public health risks. However, as an industry, laboratories historically operated quietly in the background and did not engage regulatory agencies in the same manner as other critical provider types: hospitals, physicians and pharmaceutical companies. Recently other large Medicaid programs re-procured statewide Managed Medicaid and the role of the laboratory provider was never analyzed as laboratories watched on the sidelines. We strive to do better with OKHCA as a collaborative partner. We are honored to be *'Oklahomans serving fellow Oklahomans'* and commit to stepping forward and engaging with fellow stakeholders in a meaningful manner. Our submission is intended to provide background on our experience with MCOs from a lesser known perspective and serve as a trusted partner. We welcome the opportunity to engage further on any points raised above or other topics and can be reached at Dennis.L.Hogle@questdiagnostics.com.

Sincerely,

Dennis Hogle

Dennis L. Hogle
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August 21, 2020

Reference: 80720200002

RE: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

It is with great pleasure that we take the opportunity to respond to your request for public feedback in program design relating to the establishment of a new Medicaid Managed Care Program administered by the Oklahoma Health Care Authority.

We have provided feedback to several of the categorical questions posed by OHCA (see our answers in blue below each set of questions). Additionally, at the end of this response, we have included an introductory overview into two key areas for consideration:

1. An **Operating Model** and **Maturity Rating** to apply for design support as OHCA MCO program operations are established for staffing and defining the associated business processes for oversight and performance monitoring of the MCOs.
2. Insight into how to leverage and apply **Digital Automation** to further optimize current staffing models through the automation of certain business processes.

We appreciate the opportunity to provide the following information to OHCA. Please feel free to contact us for any additional discussions on the information included in this response.

EY subject matter resources from our HHS practice at large including Medicaid Managed Care Program Operations, MCO Procurement, MMIS Technology, Supply Chain, Program Integrity / Risk Management and our Intelligent Automation (Digital / RPA) practices stand ready to assist OHCA as needed.

Sincerely,

Carrie McConnell, Client Executive, Government and Public Service

EY Health and Human Services Practice

Carrie.b.mcconnell@ey.com

678-778-4791 (c)

Section 1: Response to OHCA's Request for Public Feedback

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?

  OHCA made the strategic decision to exclude the more complex ABD population from the initial managed care roll-out. Since Oklahoma will be expanding Medicaid at the same time as implementing managed care, it makes good sense to phase in ABD population at a later date. States such as Kansas that implemented managed care with most all Medicaid populations transitioning at the same time encountered many challenges. Oklahoma should plan for future population transitions within two to three years, allowing time to identify and correct any implementation issues from the initial managed care roll-out.

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

  While there are benefits to having specialty MCOs to serve certain populations, there are also complexities with the selection, operation and contract management of specialty MCOs. OHCA should talk to states with specialty population MCOs such as Texas, Florida, and Michigan to assess the pros and cons.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

  In most state managed care programs, MCOs are required to engage members to make healthy choices. Some of the strategies include providing gift cards when for example: a child attends all their EPSDT visits; a pregnant member attends all scheduled pre-natal sessions; and a member with diabetes's completes a disease management programs. For members with food insecurity the MCO can provide transportation to a farmer's market or a store with fresh fruit and vegetables. The MCO may also offer gym memberships, enrollment in Boys and Girls Clubs or YMCA memberships to promote healthy behaviors.

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

  During this COVID-19 pandemic, Medicaid MCOs have provided for telehealth/telemedicine visits for members who do not want to have an office visit. Also successful is the availability of after-hours clinics and, in rural areas, the use of mobile medical practices. Some states encourage health plans to provide incentive payments to network providers who routinely screen for nonmedical problems such as food security, domestic abuse, housing and/or environmental hazards. Addressing these SDOH help members better access health care. Other means to improve access include assuring available transportation to attend appointments and having a smart phone app that can alert members of appointments or follow-up instructions.

- **What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?**

  One important strategy for improving the integration of physical health and behavioral health is to have PCPs screen for BH conditions. There are a number of standardized tools that can be provided to facilitate this screening. MCOs can alert PCPs to these tools and provide a BH tool kit on their Provider Website.

  In addition to screenings some of the other strategies to improve integration include:

  - Co-locating Federally Qualified Health Center (FQHC) with BH clinic practices
  - Primary Care partnership with BH providers
  - Providing performance incentive payments for improved BH outcomes within primary care practices
  - BH telehealth consults at the PCP practice
  - Medical record information sharing

- **How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?**

  MCO best practices in the area of SDOH include engagement and partnership with community-based support services. Members should receive a Health Risk Assessment on enrollment that includes identification of SDOH. Members with identified needs are flagged in the care management system for rapid follow up. Care Coordination staff provide targeted communications to social service entities to support successful intervention. MCOs often provide grant funding to CBOs to enhance available services.

  Clinical teams can also identify Members with SDOH needs and those at high risk in a variety of additional ways, including referrals from providers, clinical reviews with providers, Member advocates, and families. Referrals should be tracked in the Care Management System platform to include follow-up by care coordinators. MCOs should track and report to the state their success with social risk factor identification and interventions. This could be an area included in the state's incentive payment strategy.

- **How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?**

  Managed care plans, working together with state and federal partners, have led to the development of Innovative evidence-based intervention for behavioral health. Some innovation to improve access to SBIRT, MAT for opioid use disorder and assertive community treatment include:

  - Peer and recovery navigators based in the local communities who can conduct initial outreach to engage members, discuss availability of services, and assist in overcoming barriers
  - Dedicated care managers participating in inpatient discharge planning sessions. Use of evidence-based systematic protocols to support post-discharge follow-up visits
  - Identifying and connecting Members to Crisis Programs and other community support programs
  - Providing or arranging for mobile phones to support remote access to providers
  - Co-locating BH Providers in FQHCs and clinics

  - Employing strategies to increase the use of BH Telehealth through increasing availability, provider training and promotion, and outreach to Members about availability.
  - Develop targeted value-based purchasing programs to incentivize providers

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

  Value added services that support improving health outcomes, prevention and member satisfaction include in part:

  - Adult dental
  - Transportation (non-NEMT) – Uber, bus, gas
  - 24 hour Nurseline
  - Infant car seats, infant welcome home gifts
  - Gift cards for accessing preventive services
  - Membership at YMCA, Boys and Girls Club, Gym
  - Summer Camps
  - Fruit and vegetable baskets
  - Home exercise kits

- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

  MCOs can improve access to transportation by identifying members with transportation needs and educating members on the availability of NEMT. If NEMT is carved in to managed care, OHCA can include contractual language in the MCO contract about performance standards and remedies for failure to meet standards of timeliness and availability.

  Ride sharing services including Uber and Lyft are contracted in a number of states such as GA, MI, TN, VA, MO, AZ, DC and TX. While there have been some issues and complaints, these services fill gaps in Medicaid NEMT programs that often struggle to meet timely demand for services. Centene recently reported that for their health plans in Ohio, Florida, Georgia and Texas, Lyft reduced average patient ride wait time to seven minutes, down from the prior NEMT provider of 28 minutes. Lyft has also reported that for one MCO in Washington D.C., the use of their rideshare for NEMT decreased emergency room use by 40% for members based on claim data.

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?

  OHCA can use of value-based payments to drive performance improvements and produce better member outcomes. These can include capitation withholds and bonus pool payments. Report cards are also effective in incentivizing MCO performance. OHCA should also have dedicated contract management staff to work with the MCOs to understand and meet state expectations

  What are the most important indicators of MCO performance? Why?

The most important performance indicators are those achieve the goals and objectives of the managed care program including:

- Improving member access to care
- Keeping members healthy and out of institutions and ERs
- Reducing unnecessary health care expenditures
- Success of care management for members with high needs/ high risk
- Timely and accurate payment to providers
- Member and provider satisfaction

- What measures of health outcomes should be tracked?
  - HEDIS
  - CAPHS
  - Potentially Preventable Events (PPEs)
  - Measures that address OHCA goals for the managed care program.

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
  - Speed call answered: at least 99 percent of all calls are answered on or before the fourth ring or an automated call pick-up system is used;
  - Busy signal rate: no more than 1 percent of incoming calls receive a busy signal for the Member Services call center and 0 percent of incoming calls receive a busy signal for the BH crisis services hotline;
  - Queue Hold Rate: at least 80 percent of calls must be answered within 30 seconds after the caller's last automated menu selection;
  - Call abandonment rate: no more than 7 percent of the calls are abandoned; and
  - Average hold time: no more than 2 minutes.:
  - Accuracy: Quality audits utilizing Lean Six Sigma Methodology to achieve and sustain quality improvement with stable and predictable results.
  - Percent of first contact resolution
  - Assuring after-hours calls are answered 24 hours a day, seven days a week and operates through an IVR system which provides access to the Nurse Advice Line at any time of day or night; after normal business hours, and on weekends.

- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology.

  MCOs contract with a service that offer translation services in dozens of threshold languages and provide onsite interpreter services as required. Must call center employ a significant proportion of bi-lingual staff (usually Spanish/English). Call center staff needed to be trained in responding to inequities in non-technical terms and have member information prepared at the 6th grade level.

- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

  There is Call Center Software available for forecasting and scheduling member service representatives, IVR, call routing based on menu selection, and recording calls for quality. Also member surveys that can be administrated at the end of every call

To help members meet their health care needs there are also the following applications:

- Secure Member Portal. Member portals that give members direct access to information about their care.
- Mobile App. Smart phone applications designed to increase member participation and reduce administrative burdens. Members can access their member account information, view their digital ID card, view benefits, and find a provider. Some apps allow members to check their benefit utilization, and the types of treatment and benefits limitations that apply.
- Text Messaging. Text messaging is an effective mechanism to periodically push information to members, to remind them to complete an initial dental health assessment, to share our contact information, notification of upcoming appointments and to provide crucial health education information.
- Chat feature on website

How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

In addition to sending mail to the member, the Federal Lifeline Assistance Program provides eligible low-income households with a cell phone including free monthly data, unlimited texting, and free monthly minutes.

- How can MCOs communicate with members and receive regular input and feedback on program improvements?

  MCOs can communicate with members through:

  - Website chats
  - Newsletter with customer service calls
  - Satisfaction survey following member services call center call
  - Member advisory groups
  - Care management and disease management programs

- What tools and resources would help members search for providers? What information should be provided?

  MCO Website provider look-up and Mobile App can be used to search for providers. These resources should allow for search by specialty, location, language spoken, offering telehealth, provider quality rating, and whether accepting new patients. Data should be updated at least weekly – ideally daily. The member can also call Member Services and have the representative assist in locating an appropriate provider.

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?

  The MCOs must monitor providers for Medicaid contractual requirements such as:

  - Appointment Availability
  - Appointment Access

- Building Accessibility
- 24/7 coverage
- Balanced billing
- Reporting Abuse, Neglect or Exploitation (ANE)
- Cultural sensitivity training and other required training

To ensure that the MCOs are providing effective provider services relationships and training, OHCA should require the MCOs to perform Provider Satisfaction surveys using a survey approved by OHCA. OHCA should also require the MCOs to record provider calls and/or provide a survey following provider calls. Provider participation in training should be documented and sent to OHCA.

- **Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?**

  CMS does not allow states to set rates that MCOs must pay providers (with the exception of FQHC reimbursement). Across the country most Medicaid MCOs pay FFS rates, or when the state no longer sets FFS rates, pay a percentage of Medicare. MCOs are required to meet Network Adequacy standards and as such must enroll a large number of providers. It is in the MCOs best interest to pay the "going rate" or otherwise risk not having an adequate network. MCOs also risk maintaining membership if their networks are not inclusive. In most state Medicaid managed care programs, the MCOs pay the FFS rate for most providers and more than the FFS rate for some hard to contract specialists such as Child Psychiatrists. Hospitals sometimes demand higher rates than Medicaid FFS because Medicaid is not a large part of their revenue and they know that the MCOs need them in their network. In these cases, the state may intervene to encourage the hospital to participate.

- **What is appropriate for timely payment of claims?**

  Most states require 90-93 percent of all *clean claims* from providers to be paid within 30 days of the date of receipt.

- **What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?**

  Credentialing is one area that many state managed care programs are moving to a common practice to reduce provider burden. OHCA could talk with states like Texas, Oregon, Arizona and others that have developed a Common Credentialing Program

- **How can MCOs best communicate to providers about updates and changes to plan policies?**

  Most states require MCOs to use a provider portal to communicate with providers. They can also receive messages from their Provider Services Representative, Provider Newsletters, fax blast, or posting on the MCO provider website. If the change in plan policy is originating from the state, providers will receive those notices as they do today.

- **How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?**

  MCOs should require network providers to attend training (onsite or virtually) to be educated on requirements for submitting claims and resolving issues. MCOs are required to have Provider Relations staff available to providers to assist with contracting and billing issues. In addition,

Provider Relation staff can provide resource material to providers like behavioral health screening tools, covered benefits, best practices, etc. They can also assist providers with accessing community-based services for members that address SDOH.

- **What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?**

  Increasingly providers are being introduced to value-based payment (VBP) models that reward for quality improvements. OHCA and MCOs can work together to identify some VBP strategies that can be employed across MCOs to reward providers. It is easier for providers to participate and be successful when payment VBP measures are common across MCOs.

- **How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?**

  We understand that OHCA will require MCOs to support Patient Centered Medical Homes. MCOs can make VBP payments on the basis of primary care practices meeting the requirements for PCMH. NCQA has a PCMH designation and offers training to providers interested in receiving that designation.

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

  OHCA should establish an ombudsman office for members to call or write with concerns with the managed care program and their MCO. This office could be contracted out or reside within the agency. It should not be part of the Managed Care operations but rather report to an independent division. The number for this office should be published on the MCO website, OHCA website, in the Member Handbook and other places where members might go to get information. The ombudsman staff may work directly with the MCO on resolution of complaints or work with the MCO's OHCA assigned contract manager.

  The MCOs should have a Member Advocate position. This position could reside in the Member Services division; however, it should have a dedicated function of assisting members with concerns and grievances. The MCO should track and report all complaints and resolutions and categorize for management review. Reports should be reviewed and trended to identify areas for problem correction.

  All complaints should be reported back to the OHCA contract management division for consolidation and review by OHCA staff and corrective action plans developed if necessary.

- How can the state and MCOs use appeals data to improve utilization management and access?

  OHCA and the MCOs can use appeals data to assess whether there has been inappropriate denial of a particular service or category of services by the MCO. Many MCOs will make changes to Prior Authorization requirements as a result of appeals filed. They may also learn that a Medicaid benefit is being inappropriately denied. This may require revision to their claims processing system.

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate

  The currently recognized standard for health care information sharing is the use of nationally recognized X12N-Insurance Transaction Sets and related electronic data interchange (EDI) standards. These standards are compliant with HIPAA requirements. The data sharing information could include:

  - Clinical and medical record data
  - Care plans
  - Population health data that supports providers closing members gaps in care
  - HEDIS measures

- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

  There are barriers to data sharing with providers. Interoperability and data variability are a huge challenge. Identifying and capturing relevant data that can be used by the MCO care management team is problematic along with inconsistent formats. Some providers are reluctant to share data as they may not see the benefits. Also, as noted, some provider lack the resources and technology.

  The CMS final rule published March 9, 2020 - the Interoperability and Patient Access rule - requires MCOs to make member data accessible using a common data sharing standard. It also requires hospitals to send electronic admissions, discharge and transfer information to patients' primary care providers.

- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

  OHCA should provide support for MCO identification and referral of cases of suspected fraud or abuse. OHCA should provide training to MCOs on methods for identifying fraud and share best practices about approaches and tools to increase recoveries. MCOs can use available technology to analyze claims data for potential fraud. They can also employ clinical audits when fraud is expected.

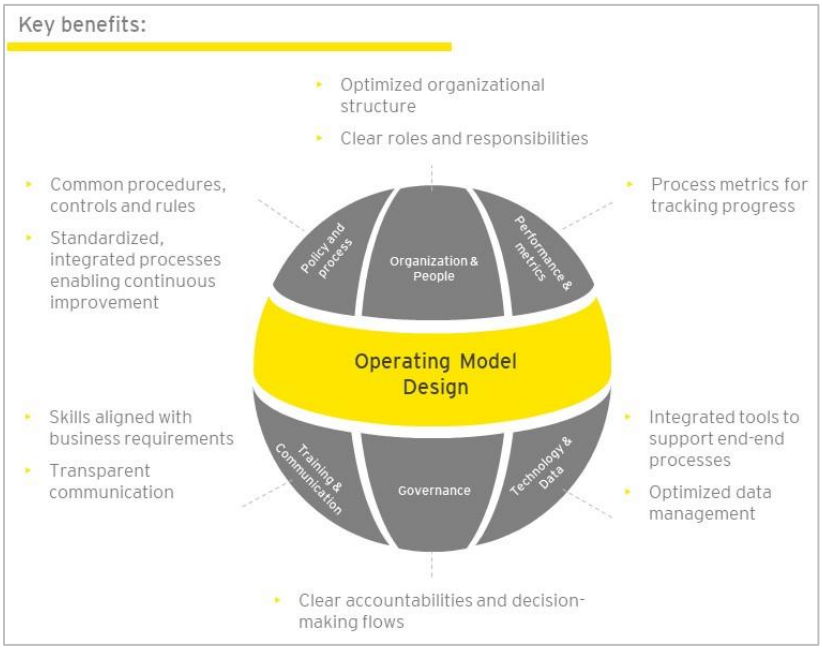
Topic # 1 for Additional OHCA Consideration: Operating Model

#1 Managed Care Challenge: High Administrative Costs for Both State Agencies and MCOs

A 2018 Health Affairs analysis of Medicaid Managed Care Organizations (MCOs') insurance regulatory filings from 2016 and 2017 revealed a large variation in the amount of administrative overhead among states' managed care plans, and a 37 percentage-point spread in the percentage of MCO revenues that are spent on actual care. While there is not enough data at this point to determine the causes of the variations, employing accountability on the MCOs' can level out the spread.

Staffing and political pressure are constant challenges in many States. For one, states are often short on staff to manage MCO's and the rules around managing are very detailed and complex. If MCO's are not set up properly, states could be wasting billions of dollars since Medicaid spending claims almost 20 percent of state general funds (not including matching federal funds). The need for more transparency around management of managed care continues to be a hot-topic for governors, state Medicaid agencies and MCOs given their need to demonstrate that Medicaid managed care dollars are spent appropriately.

Innovative Solution: Operating Model to Optimize Medicaid MCO Program Establishment and Administration



To address the many challenges faced by OHCA, it is critical to employ an Operating Model which clearly defines, prioritizes and shapes investments in business processes and technology enablers, serving as the foundation for MCO contract execution, administration and oversight. This is a best practice approach crucial at onset of planning to make sure there is alignment to the approach at the onset of the RFP release/evaluation period (day one) and to identify performance objectives to monitor adherence to goals as MCOs are implemented and the program goes live.

How does an Operating Model Work?

An operating model defines how the strategy will be executed and will drive MCO performance via the following categories:

- Process/ Business structure
- Organization structure and operating locations
- Governance and decision making
- Performance metrics and accountability
- IT infrastructure

Without a clear operating model, organizations struggle to bring preexisting, efficient capabilities and processes to new strategic initiatives. Additionally, research indicates that companies with a

clearly defined operating model report significantly greater performance across a range of outcome metrics including: operational efficiency, consumer/member approval, plan leadership, and strategic coordination and collaboration of joint goals and objectives between States and MCOs.

Once the operating model is established, evaluation of MCO maturity is employed to assess the maturity of organizational capabilities along eight (8) dimensions which include: strategic direction, people and organization, knowledge management, technology, stakeholder management, procure to pay process, performance management, and supplier relationship management. Each dimension is rated based on a 5-level maturity rating and is based on industry best practices.

Why a 5-level maturity rating?

- MCOs are complex; there are many moving parts
- A maturity model is needed that adequately encompasses the breadth and depth of the MCO processes
- Demonstrates progress over time and allows adequate room for differentiations and targets for progress

Level	Definition
1 Basic	The capability in the dimension is either not yet in place, or exists in a limited ad hoc and uncoordinated fashion. **Key words: Ad hoc; reactionary; functional silos**
2 Developing	There consists some basic documentation around the dimension with plans for improvement and/or execution. Some basic metrics may be defined for measurement. **Key words: Documented; planned; repeatable; metrics**
3 Established	The dimension is formalized, with an established structure around management and measurement. It is now well integrated into key areas. **Key words: Integrated; measured; managed**
4 Advanced	The capability described in the dimension is integrated throughout the organization, with regular performance measurement against established KPI measures. **Key words: Proactive; cross functional integration; key performance indicators**
5 Leading	The dimension has surpassed the advanced phase and would be considered a leader when benchmarked against its peer group. There is a focus on proactive continuous improvement. **Key words: Benchmarking; continuous improvement; adaptive to change**

Benefits to OHCA – Incremental and Defined Path towards Managed Care Program Maturity

OHCA's consideration for adoption of an Operating & Maturity Model based, organizational design would be proactive effort in mitigating downstream issues and risks as MCO selection, contracting and program role out steps are taken.

EY suggests an approach that can complement and operationalize the solid strategy and procurement work that OHCA leaders, with the help of HMA, have already completed. Implementing this model brings a purpose-built and proven roadmap to reinforce the strategic planning; procurement and evaluation alignment with performance-based contracts; and, design and implementation of an organizational (staffing & business process establishment) working model to oversee the MCOs.

Topic # 2 for Additional OHCA Consideration: Digital Automation

In the spirit of the aggressive timeframe in which OHCA has set to procure, award and implement the MCOs, we believe it would be beneficial to consider optimizing certain business processes that support procurement, operations, oversight and performance monitoring, and reporting.

Benefits to employing automation include: Improved efficiency and productivity, reduced errors in manual tasks, faster end-to-end process turnaround, improved data accuracy/consistency and administrative cost reductions through re-purposing existing staff.

We believe there are several "business process & program candidates" that could immediately be reviewed for automation feasibility and establishment at the onset of the OHCA MCO program administrative operating model. The following lists a few examples of immediate areas for consideration:

- MCO portal for deliverables
- Deliverables IT system that has the following functionality in part:
    - Provides notice to MCOs of deliverable due dates

    - Assigns deliverables to the appropriate staff for review
    - Provides confirmation of deliverables received
    - Reports back on performance on key metrics
    - Can run standard and ad hoc reports
- Online Training modules for staff on new operational procedures
- Automated "playbooks" for staff on requirements, policies and procedures for management of the MCO contract and performance and documentation requirements
- Encounter claim reviews

The EY Intelligent Automation practice, rated #1 Globally for RPA implementation, has recently helped several state government agencies improve overall business operations through the establishment of various automation solutions.

It has been our experience that every organization – public and private sector – can drive cost containment, accuracy and efficiency through the automation of certain business processes that are currently manual, paper review intensive. As a matter of fact, Industry leaders predict that *"**60%** of organizations over $1 billion in annual revenues (or program spend such as OHCA) have begun their automation journey. By 2022, IA adoption, in some form, will have reached **85%**"*

In summary, EY stands ready to further discuss and assist OHCA as the move to a Managed Medicaid program continues. We appreciate the opportunity – Thank You!

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SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design
Planned Comprehensive Medicaid Managed Care Implementation

Comments and suggestions about MCOs from my 8 years of patient advocacy in Oklahoma and 35 years of private medical industry involvement are presented below. I'd be pleased to expand comments on any of these topics, or talk with OHCA or other stakeholders. Thank you for your consideration.

Steven Goldman, PhD The Village, OK
stevenBgoldman@gmail.com 405-371-0136

Note: My comments are in the yellow highlighting. Full text of the form is kept greyed-out for context. These are my own personal comments, not as a representative of any group or employer. Thank you.

~~OHCA will accept responses from any interested party including individuals and program participants, providers, trade associations,companies and other organizations. Responses need not address every question. Responses should be submitted by 5:00pm Central Time on August 21, 2020. Responses should be submitted via email to Procurement@okhca.org and can be submitted as a letter attachment. Please reference 80720200002 in the subject line of your response.~~

~~**Comprehensive Managed Care for Oklahoma: A Key Tool for Program Improvement**~~

~~Oklahoma is pursuing a comprehensive Medicaid managed care approach that will allow the state to achieve its payment and delivery system reform goals:~~

Improve health outcomes for Oklahomans

Is the plan to use current 2019-20 outcome data as baseline, or baseline starts after 1 year of managed care? What outcomes will be assessed for improvement, and will all MCOs have the same outcomes measured? OHCA needs to make clear what outcome measures over what time periods would be compared to detect "improvements". OHCA needs to set goals for outcomes, so it can be determined if "improvements" are actually achieving goal-markers.

~~Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume~~

Improve member satisfaction

What will the baseline period be for "improvement"? Current 2019-20 satisfaction data as baseline, or baseline starts after 1 year of managed care? Any "satisfaction" measures need to have a comparison point and a time frame. Simply asking "how satisfied are you with your medical care?" for a Medicaid member has the implicit comparison of "compared to having no medical care at all." Proper survey items

might be: Compared to other health insurance you had in past 5 years, how satisfied are you with this MCO? In the past 6 months.....how satisfied are you with how quickly you could get medical care? Getting medications when you needed them? Getting medical care at times that did not interfere with your job or family needs? Of course, these satisfaction surveys will need to be validated by independent means, not just relying on MCO to report on themselves.

~~**Contain costs through better coordinating services**~~

~~**Increase cost predictability to the state**~~

~~The following sections provide information on the planned managed care program and identifies areas where additional input is requested.~~

~~Managed Care Enrollees~~

~~**Managed Care enrollment will provide SoonerCare members with better access to a system that is more**~~

~~**coordinated and has greater cost predictability.**~~

~~To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.~~

~~Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service~~

~~Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for service Medicaid~~

~~Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting~~

~~MCOs will serve members across the state~~

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

What information will be available to new members to make their choice of plan? Since all plans will be "new", there will not be satisfaction ratings available (as with Medicare pan "star ratings"). Basic data for each MCO for an informed decision by new members may be: How many PCPs within a 30-minute drive? How many hospitals? How many pharmacies? When is the soonest guaranteed appointment available? Providers available after 5pm within 30 minute drive (including Urgent Care centers). Telehealth hours, for example, 6am to 11pm. Listing of special programs for Diabetes, Addiction, etc. Links to look-up providers, hospitals, etc. (as with HealthCare.gov).

This info screen should also remind members that they can change MCOs every month (or whatever the rule is).

In place of "satisfaction" ratings results, the member choice screen may show the percent of members who chose each plan in that zip code or county.

Questions for Stakeholder Input: Enrollees

How and when should OHCA transition ABD and other initially excluded individuals to managed care?

Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

There is concern that MCOs will be allowed to "cherry-pick" patient populations which are more easily profitable, based on demographics or geography. As a start-up program in Oklahoma, MCOs should take all patients, then present data showing their success with certain sub-populations after 2 years, before OHCA allows special population MCOs. The concern is that an MCO may "promise" better service to foster kids or the mentally ill, but they should have to "prove" it with sufficient providers and programs for 2 years of outcome data. As this OHCA proposal calls for coordinated and holistic care, it is difficult to expect that an MCO will be able to have sufficient specialty and primary care networks when limited to a smaller patient population.

How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

There is conflict between an MCO's profit motive of narrow networks versus "more" doctor visits and "more" patient contacts for treating tobacco cessation and lessening obesity. OHCA contracts with MCOs must set measurable goals to be met, with both penalties and incentives. More reliance on Community Health Workers (CHWs) who can engage with their local populations may be an answer when both medical and social changes are needed. However, compared to other states, where does Oklahoma stand on CHW certification or "ability to bill" for services?

~~Benefits Provided through MCOs~~

~~**Managed care enrollees will receive the same benefits and services they receive currently, plus**~~

~~**some extra benefits.** The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members.~~

In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

Allow reimbursement for co-location of physical health and behavioral health services

Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable

Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

Screening enrollees for social needs

Providing enrollees with referrals to social services and tracking the outcomes of referrals

Partnering with community-based organizations or social service providers

Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

From my experience talking with SoonerCare members, a major access barrier is the unrealistic time frame of 9-5 M-F for services. Those are prime job working hours, but their jobs do not offer "paid time off" and employers expect constant job attendance. Although members may be strongly committed to their health, the income range for SoonerCare means members cannot reasonably lose paying job hours for medical care. Also, previous communication from OHCA seems to indicate that working or community engagement is vital (HAO proposal), so the agency should ensure that MCOs provide services at times which do not conflict with member working hours, or community engagement times.

Similarly, many SoonerCare members have all-day responsibilities for children or other family members, so cannot attend to their own health until

evenings or weekends. Even if not working, members may not have transportation until friends are off-work, so the 9-5 M-F appointments are not available to them.

The successful MCO will have primary care providers available until 9pm weekdays and on weekends, or contract with urgent care centers. Telehealth should be available until midnight, since SoonerCare members in the service occupations may be working until the 10pm close of their businesses. Contracting with 24-hour pharmacies or the latest-open pharmacy in each town of over 5,000 populations should be required. This means members can complete their involvement with care by filling prescriptions, plus this policy supports locally-owned pharmacies across the state.

~~What strategies would improve the integration of services (especially behavioral and physical health),~~
~~including through provider communication, shared assessments and planning, and data sharing?~~

How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance?

MCOs should be responsible for both referrals and tracking outcomes. As OHCA creates a standard Social Determinants of Health (SDOH) survey, MCOs should add it to the patient records and report quarterly on outcomes. It will be important to understand that although the MCO gets paid for doing the SDOH assessment, the referral likely goes to an underfunded Food Bank or housing agency. The OHCA will have a valuable database for the agency to advocate for more financial support for social services. OHCA may suggest that MCOs contribute to the social service agencies to which they refer patients, since the better medical outcomes lead to higher profits for the MCO.

~~How could OHCA measure MCO performance on social risk factor mitigation strategies?~~

~~How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief~~
~~Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or,~~
~~assertive community treatment?~~

What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

Most impactful would be services available on evenings and weekends, such as telehealth and late-night pharmacy. This helps lessen the conflict between job working hours and care access hours. A successful MCO would contract with providers who stay open on evenings and weekends (or urgent care centers), plus late-night or 24 hour pharmacies so there is quick follow-through on starting or refilling medications. Member satisfaction will likely be high when health care is available without loss of hourly paid job time and with immediate benefits of medical advice and needed medications.

~~How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?~~

~~Quality and Accountability~~

~~**MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.**~~

~~OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.~~

~~Areas for quality measurement include population health goals identified as **state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**~~

~~MCOs will **reimburse providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions~~

~~**OHCA is investigating the use of incentive measures, quality pools and other programs;** MCOs will participate in OHCA efforts to provide enrollees access to quality health care~~

Questions for Stakeholder Input: Quality and Accountability

What mechanisms should the state use to incentivize MCOs to improve member outcomes?

Along with incentives, there should be penalties when member outcomes are not improved. How to design financial penalties for low-performing MCOs so providers and patients are not adversely affected? As with Medicare Part C/D plans, particular MCOs might be de-listed from consumer choices for a period of time. Perhaps OHCA transfers to the MCO could be lowered to actual provider

reimbursements plus 1%, or actual MLR+1% until the MCO shows it can perform well. Members should not feel stuck in a badly-performing MCO, so OHCA may send a message to all members in that MCO with a reminder that they can change to another MCO.

What are the most important indicators of MCO performance? Why?
What measures of health outcomes should be tracked?

At a minimum, the indicators and measures that were proposed for HAO should be used for consistency with other Medicaid programs. There are existing reporting tables that cover Adult Core Set quality and outcome measures, plus access and financial (MLR) records for quarterly disclosure. Any lesser reporting would mean that OHCA is allowing MCOs less oversight than the agency was proposing for itself. See pages 54-55, Figures IX.1 and IX.2 in https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-soonercare-2-pa.pdf

~~Care Management and Coordination~~

~~**MCOs have experience managing members' health, including for populations with complex or multiple**~~

~~**needs.** Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding: Prior authorization (PA): services subject to PA, timeliness standards for approval Use of practice guidelines~~

~~Utilization management program standards to support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:~~

~~**Conduct health screenings** to identify ongoing need, current providers, and social determinants of health~~

~~**Develop care plans** for identified enrollees and **establish care management and care coordination** based on identified risk and particular health conditions~~

~~**Design health management programs** with a holistic approach to member health~~

~~**Conduct health education** in priority areas and on emerging issues~~

~~In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.~~

~~Questions for Stakeholder Input: Care Management and Coordination~~

~~How can utilization management tools work best for members and providers?~~

~~How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?~~

~~What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?~~
~~How can MCOs improve the management and coordination for members with chronic or complex health conditions?~~
~~What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster~~
~~care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?~~
~~Member Services~~
~~**Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance,** to include:~~
Answer member questions timely via telephone or email and resolve grievances and appeals timely
Frequently update provider directories online to help members locate health care providers

Please do not use fuzzy goals like "timely" or "frequently". OHCA must set specific goals and penalties (as they do for members who do not provide needed documentation). For example: Provider Directories updated each month. Member questions and grievances answered within 3 business days. Penalty may be $5000 per occurrence paid within 7 business days, or OHCA may delay next payment to MCO by 3 days.

~~**Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels~~
Questions for Stakeholder Input: Member Services
What metrics should be used to measure MCO performance with regards to member services?
How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

This is where Community Health Workers may be most helpful. Also, during telehealth, translators can easily be added. How will OHCA monitor "best service" practice of MCOs? Will outcome or satisfaction scores be reported by language, race or ethnicity?

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

In the income bracket of Medicaid, it is much more likely that a cell phone is used for internet access, rather than a home computer. This is even more true in rural areas of Oklahoma. Happily, MCOs are large, commercial companies who have existing agreements with large cellular companies, so have business contacts and

influence with cell companies serving Oklahomans. As MCOs find telehealth and e-messaging patients to be cost-effective, an MCO may offer discounts or reimbursements to members or find ways to make data services needed for telehealth "free" for members (as with 800-number phone lines). MCOs may find it efficient to send to members cell handsets which are pre-set for telehealth only, just as commercial cell companies offer "free phones" for their network.

~~How can MCOs communicate with members and receive regular input and feedback on program improvements?~~

What tools and resources would help members search for providers? What information should be provided?

Members should be able to search for providers prior to enrolling in an MCO (as with HealthCare.gov) either through the SoonerCare website or an 800-number. Importantly, timely access may be the key criteria for members who do not have an established PCP. "How soon can I see a provider within 30 miles or via telehealth without missing work hours?" may be the member's decision point.

Basic data for each MCO for an informed decision by new members may be: How many PCPs within a 30-minute drive? How many hospitals? How many pharmacies? When is the soonest guaranteed appointment available? Providers available after 5pm within 30 minute drive (including Urgent Care centers). Telehealth hours, for example, 6am to 11pm. Listing of special programs for Diabetes, Addiction, etc. Links to look-up providers, hospitals, etc. (as with HealthCare.gov).

This info screen should also remind members that they can change MCOs every month (or whatever the rule is). In place of "satisfaction" ratings results, the member choice screen may show the percent of members who chose each plan in that zip code or county.

~~Provider Payments and Services~~

~~**Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.**~~

~~As required by CMS, do not pay a provider for provider-preventable conditions~~

~~Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed~~

~~Pay Indian Health Care Providers at the encounter rate whether or not they are in-network~~

~~Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider~~

~~Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud~~

Maintain and/or expand telehealth availability

There may be useful partnerships between MCOs and the many Federally Qualified Health Centers (FQHCs) in Oklahoma, mostly located in rural areas. The FQHCs provide excellent community-based primary care, and their sites can include rooms for telehealth with the MCOs specialists. In a rural town, the FQHC and the library may have the only robust internet connections available for telehealth.

~~Questions for Stakeholder Input: Provider Payments and Services~~
~~What metrics should be used to measure MCO performance with regards to provider services? Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished?~~
~~How should the state sustain provider compensation?~~
~~What is appropriate for timely payment of claims?~~

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:
Examples of industry standards include:
Primary care medical home appointments within 30 days from request for routine care, 72 hours for nonurgent sick care, 24 hours for urgent care
Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care

These standards must be clearly communicated to members at the start of SoonerCare membership. For example, the web page where members choose an MCO should include: "All plans must provide appointments within 72 hours for nonurgent sick care and 24 hours for urgent care. **If you do not get appointments within these time limits,** please contact the SoonerCare OHCA 800-number or text to OHCA at _____." This ensures that OHCA knows when MCO is failing to meet standards quickly enough to provide proper member services.

Require all Primary Care Providers have at least <u>some</u> same-day acute care appointments

"Some" needs to be defined by OHCA; otherwise it means "1" appointment left open.

~~Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)~~
~~Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees~~

~~Questions for Stakeholder Input: Network Adequacy~~

~~How should MCOs work with providers to ensure timely access to care standards are met? What are reasonable time and distance standards in Oklahoma by provider type? How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? How should MCOs support workforce development for different types of providers, including pediatric dentists pediatric psychiatrists, primary care providers, and behavioral health providers?~~

~~Grievances and Appeals~~

~~To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes.~~

Grievances and appeals can be filed by members or providers on their behalf.
MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
MCOs will resolve grievances in writing within 30 days

All member complaints, appeals, grievances will be copied to OHCA, so the agency maintains an independent database of problems, and can look itself for patterns that may be early warnings of MCO failures.

~~Questions for Stakeholder Input: Grievances and Appeals~~

How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

At monthly OHCA board meetings, a summary table of member concerns for each MCO should be presented. A metric should be developed to "flag" any poor performing MCOs, such as complaints-per-100-members. Again, all member complaints, appeals, grievances will be copied to OHCA, so the agency maintains an independent database of problems, and can look itself for patterns that may be early warnings of MCO failures.

How can the state and MCOs use appeals data to improve utilization management and access?

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

Gain accreditation by a federally-approved accreditation body (NCQA, URAC, AAAHC)

Maintain an Oklahoma presence, including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work

Please further define this 100-mile rule in terms of expected outcome. Is the goal: "MCO will have senior executive appear at OHCA within 2 hours of request by OHCA staff"? Or, is the goal economic development? "MCO will lease at least 10,000

square feet of office space, preferably at the renovated buildings on Lincoln Blvd, north of OHCA HQ"? Otherwise, an arbitrary 100 mile rule (rather than "in-state") seems designed to favor or exclude certain companies, or prefer a vendor close enough to plausibly take OHCA staff out for meals.

~~**Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans~~

~~Questions for Stakeholder Input: Administrative Requirements~~

~~How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care? What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?~~

Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

It is definitely <u>not</u> a good idea to have a Marketplace requirement. More insurers in the state's Marketplace may mean higher premiums for all consumers. For 2020, a third insurer came to the Marketplace OKC market, which depressed the tax credit discounts, meaning higher premiums for many. This third insurer offered plans in only 3 counties, but affected tax credit discounts in all 7 OKC metro counties. An MCO offering a Marketplace plan in just 1 rural county may reduce tax credit discounts in over 50 counties in the state. There are currently over 150,000 Oklahomans with Marketplace plans, an increase of 5% over 2019. Please contact me for more info on this topic.

A requirement to offer a Marketplace plan is counter to the idea of "special-group" or specialized care MCOs, since a Marketplace plan must be fully general.

It may be helpful for MCOs to offer Medicaid-Medicare "Dual Eligible" plans, including special population plans.

Thank you for your consideration.
Please be in touch if I might further assist.
Steven Goldman, PhD The Village, OK
stevenBgoldman@gmail.com 405-371-0136

Oklahoma Health Care Authority (OHCA)

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

RESPONSE DUE:
August 17, 2020, 5:00 p.m. CST

Health Management Systems, Inc. 5615 Point Drive, Irving, TX 75038
Phone: 401.301.1461 Fax: 469.359.4413

August 17, 2020

Oklahoma Health Care Authority
Procurement Office
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

via email: Procurement@OKHCA.org

Re: Oklahoma Health Care Authority (OHCA) Request for Public Feedback 80720200002

Thank you for the opportunity to respond to your Request for Public Feedback. As is evident by the questions, Oklahoma Health Care Authority (OHCA) is looking to leverage innovation to drive greater member engagement and satisfaction while driving out cost.

HMS has helped many state organizations like OHCA deploy true cost avoidance solutions across the care continuum, which starts by keeping members healthy and out of the emergency room. Although HMS has historically been viewed as a company focused on payment accuracy, over the past ten years HMS has aligned its resources to be a member centric and end-to-end cost avoidance organization.

Our solutions align very closely with the questions that were asked:

- Coordination of Benefits
- Payment Integrity
- Population Health

We look forward to discussing in greater depth how HMS can leveraging our extensive experience, specialized processes/tools, and commitment to improving the healthcare system.

I will serve as our Executive Sponsor for this project. Please do not hesitate to contact me via telephone (484.919.3000) or email at Daniel.Wittner@hms.com with any questions about HMS or our services.

We really appreciate the opportunity to present our thoughts and insights. And, we look forward to further conversations with OHCA to build a better quality health experience for Oklahomans.

Sincerely,

Daniel C. Wittner
Vice President

5615 High Point Drive | Irving, TX 75038 | Telephone: 214.453.3000 | Fax: 469.359.4413 | hms.com

Table of Contents

1. ENROLLEES

1. How and when should OHCA transition ABD and other initially excluded individuals to managed care?

HMS does not have a response to this question.

2. Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

This is a difficult question to answer with a definitive yes or no. Several states have carved out these special populations to better serve them. Others have chosen to allow MCOs to handle all of these except for the American Indians/Alaska Natives, which is a unique population, given the Social Determinants of Health (SDoH) dynamics. Providing traditional and behavioral care should be specialized and targeted to this population.

3. How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

The critical answer is acknowledging the type of engagement which successfully gets individuals engaged may be different for everyone. The health plans have long tried to improve engagement, but they have not gotten the traction they would like. Substantial investments are being made now by health plans to drive engagement with the members as they know this will lead to true cost of service avoidance and happier membership.

The really important point to make is it is not just engagement. It is targeted engagement driven by data and analytics. If you can determine a medium or low risk member prior to them shifting into high risk and reach-out to them, you have a greater chance to avoid the situation getting worse.

HMS provides best in class solutions for data mining and analytics coupled with our engagement platform. These tools, Eliza and Elli have been helping plans drive better outcomes with their members for years and can be leveraged for OHCA.

2. BENEFITS

2.1 What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Virtual Care is all the rage now due to COVID-19. This inflection point in providing access is going to more the norm going forward. Incentivizing the Members and Providers to leverage these technologies will be critical and providing the right reimbursements to the Providers will enable this.

Mobilization: Using ride share companies to transport people to and from their in-person doctor visits will be key as well. These services are far less expensive than traditional medical ride companies. The OHCA needs to ensure these are part of the equation in their reimbursement rates.

2.2 What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Data sharing is the most important part of this strategy. The providers use multiple electronic health record (EMR)s today, which are closed. Allowing health plans access to EMR data would improve care. Also, OHCA should look at having a standard care management platform across all MCOs. The key is that the data critical to engaging members can be centralized and accessed easily to help manage members as the potentially shift between MCOs. An additional benefit is having standard care protocols that all MCOs follow and manage to.

HMS is working in other states to leverage our care management platform, Essette, which is a robust platform that can easily integrate with EMR data. Combined with our data mining tool, Elli, the platform effectively allows the health plans to have a consistent approach to high risk populations, while driving costs out of the system and increasing member satisfaction and health.

2.3 How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

The best way for MCOs to facilitate and track the outcomes of referrals is to have a common platform for all agencies. Like 2.2, providing access to a centralized care management platform would essentially provide CRM for all members and activity. It would easily allow for the tracking as everyone would input the data to the platform. This issue is exactly what another very large state is tackling with this type of solution.

2.4 How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

HMS is seeing a shift in approach to Behavioral Health and Care Management, which has traditionally been done, and tracked, separately. We have seen several states even break-up behavioral contracts across counties leaving access to care and evidence of care almost impossible to track.

As many people are seeing in healthcare, depression and other disorders are presenting themselves due to the confinements of COVID-19. his is driving us to a more Whole Care model to incorporate Care Management and Behavioral Health into a combined approach. Combining and supporting these with the right centralized technology framework and care coordination, HMS feels we can deliver a greater impact on identifying and treating earlier in the care cycle these issues.

2.5 What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

As mentioned in previous answers to questions in this section, leveraging technology and data combined with new virtual care tools can have a significant impact in healthier outcomes, better member satisfaction and allow the MCOs to prevent through better engagement.

HMS' tools can help in all areas. Eliza, Elli and Essette come together to provide the best in class framework to allow OHCA to drive costs out by being more preventative which will create a happier and healthy membership.

2.6 How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Yes. Ridesharing is an effective tool to drive out costs. What HMS has seen in other states is the need for a service to sit on top of UBER and LYFT to monitor the use and the places that people are taken. Managing abuse is critical to achieving what can be a great solution to getting people in to see their physicians.

3. QUALITY AND ACCOUNTABILITY

3.1 What mechanisms should the state use to incentivize MCOs to improve member outcomes?

Medicare has multiple incentives tied to healthy outcomes. These types of metrics can be monitored and incentivized if access to the data is provided.

3.2 What are the most important indicators of MCO performance? Why?

HMS recommends following CMS' guidelines.

3.3 What measures of health outcomes should be tracked?

HMS recommends following CMS' guidelines.

4. CARE MANAGEMENT AND COORDINATION

4.1 How can utilization management tools work best for members and providers?

Utilization Management (UM) tools can reduce abrasion for members and providers by simplifying the process. Health Plans need to simplify the prior authorization process to enable simple requests to be automated and approved and the more complex referred.

HMS has several pre-authorization solutions to enable the UM process to work more effectively. These clinical tools are applied when the request is submitted, which eliminates significant abrasion early in the process for members and providers.

Procedures which are complex and may require more intense review should be done in an expedient manner. Timeliness of response to provider creates undo stress for the provider and member.

HMS has the tools and processes to help streamline the processes for all the OHCA MCOs.

4.2 How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

Reduction of administrative burden is outlined in 4.1.

4.3 What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

Network adequacy is critical to meeting the care and behavioral needs of the members. Additionally, expanding access to Virtual Care would have a significant impact. Oklahoma is a large state with considerable rural access issues. Creating alternative access for simple issues would dramatically increase usage and prevent care and behavioral issues.

4.4 How can MCOs improve the management and coordination for members with chronic or complex health conditions?

Data is key to achieving the types of improvement in chronic populations. Having data and being able to analyze and build predictive models can significantly improve the management and coordination of care. Additionally, adding virtual care tools that can be monitored remotely such as Pulse/Oxygen, weight, blood pressure and blood sugar can be used as early identifiers of issues that need to be addressed. Couple these with the virtual visits, OHCA can have a material impact on early intervention and drive a healthier population.

Another area is the predictive outreach previously mentioned. Leveraging data to predict issues and engage with the members can have a significant impact.

HMS has the tools to assist in all these areas to help OHCA achieve a more cost sensitive care solutions that drives better member satisfaction.

4.5 What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

HMS does not have a response to this question.

5. MEMBER SERVICES

5.1 What metrics should be used to measure MCO performance with regards to member services?

Member service metrics should be consistent with all plans. First Call Resolution (FCR) is a key leading metric, which can be provided by the MCOs at point of contact. CSAT (Customer Satisfaction) measurements are more of an ongoing/outreach metric, as all the data from all points of contact are challenging to collect and aggregate.

HMS' tools like Eliza can assist in conducting outreach to members to collect the surveys and report on the CSAT. Elli can help aggregate all data and provide a more holistic view of the satisfaction of the member population.

5.2 How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

MCOs should ensure they are leveraging the basic tools in the market to make the plan bi-lingual. Oklahoma has a large Hispanic population as well as a large American Indian population. Website tools provided by Google Translate can assist with those. Call center support should include an IVR for the Hispanic population, as well as a bilingual agent to help the members at the phone switch.

5.3 How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

Leveraging technology is key to the modern health plan. Web based applications should be enabled with mobile formatting to make it easier to access and consume the data. Texting options should be allowed in opt in to allow the health plan to do simple outreach for care and medication reminders.

The mobile phone is now the primary source for all information. The ability to engage members through the phone via call or text is very important. Also, enabling the health plan App to be able to push content to the Smart Phone is another important useful tool to help drive better engagement and adherence to the member medical protocols.

5.4 How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

MCOs can best communicate with traditional tools like landlines, mail and in-person connections. HMS has tools that can predict the best medium to connect with and when. Our Eliza tool is a leading-edge solution to get the maximum connection rate with the members especially those with connectivity issues.

5.5 How can MCOs communicate with members and receive regular input and feedback on program improvements?

MCOs can conduct ongoing points of contact to get customer feedback on plan benefits and service quality. MCOs will need tools to do the outreach or look to partners that do this for other health plans. HMS has seen a significant need for our Eliza solution during COVID-19. We have seen plans use Eliza to communicate, engage and educate member on their concerns and how to best get care. Also, these points of contact have provided material insights to member concerns and fears and allowed the health plans to create content to address those.

Having a proven outreach solution can really help the MCOs better care for Oklahomans.

5.6 What tools and resources would help members search for providers? What information should be provided?

Having a best in class Provider Directory online that allows people to identify and better understand Providers easily is a must have today. Our partner solution can provide everything your member needs to know about providers which include:

- Types of services provided
- Insurance types supported
- Location
- Mapping information
- Recommendations of other member/patients
- Hours of service
- Stars for level of service

Additional information can be easily added to the website.

6. PROVIDER PAYMENTS AND SERVICES

6.1 What metrics should be used to measure MCO performance with regards to provider services?

CMS has standard metrics for providers that should be measured and followed.

6.2 Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

HMS does not have a response to this question.

6.3 What is appropriate for timely payment of claims?

Timeliness of payments is an issue that all health plans must address. Many health plans are moving to a point of service (POS) model, as they believe the faster they pay, more likely it is that members are satisfied and provider abrasion is reduced. Other plans are getting reimbursements down to weeks as they focus on keeping providers satisfied.

6.4 What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

The provider functions that should be standardized are Credentialing, Provider Directories and Provider Data Management. Having partners to manage these processes can ensure the process is simple and effective.

The issue to getting this done is everyone wants to do it their way which adds cost and complexity. OHCA can dictate these processes and drive adoption across the state.

6.5 How can MCOs best communicate to providers about updates and changes to plan policies?

There are several ways to communicate with providers about changes and plan policies. For example, a centralized Provider Portal that interfaces with the provider creates a simple but highly effective way to communicate and educate on changes. A portal that is mobile-ready will enable ease of access for smart phone users. Other traditional ways of communicating are phone, mail, and text.

HMS can help identify the most effective solutions and engagement strategy.

6.6 How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

As mentioned in 6.5, providing a Provider Portal that is integrated to provider billing systems would be an optimal solution. This would allow for ease of billing and reconciliation, credentialing and uploading of current information, Provider Directory real time updates, and education.

6.7 What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

Shifting from a Fee for Service model to a Value Based Care (VBC) model can be a challenge due to real time data access from the health plan. If the OHCA and MCOs can provide the data required to the doctors in real time or near real time basis, then the argument to move to a VBC

contract becomes less of an issue. If there is a transition model that the MCOs want to suggest as they get the data prepared, then that could be the bridge to acceptance.

Providers who have raced down the path to a VBC model have looked at significant time to value impacts. In one specific case, there was a lag of more than 12 months to receive the incentive payments due to the lack of available data.

HMS' Elli solutions can help aggregate the data and provide the payment methodologies required to help the transition begin.

6.8 How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

MCOs can assist primary care physicians (PCPs) by continuing the care management outreach and coaching. The MCOs need access to the PCP data in their individual EMR. This is a key blocker to getting the kind of true collaboration in care. If that data sharing is in place, then care managers can collaborate with physicians on the right care. Too often, doctors feel the care managers are not in sync with what they are doing for the patient. To get maximum impact, get the data interoperability to address this and then put training programs in place to ensure doctors and care managers know how to effectively engage with the members.

HMS' Essette solution can help bring the data in and provide care protocols that are consistent with best practices. This can drive better outcomes and member satisfaction.

7. NETWORK ADEQUACY

7.1	How should MCOs work with providers to ensure timely access to care standards are met?

HMS does not have a response to this question.

7.2	What are reasonable time and distance standards in Oklahoma by provider type?

HMS does not have a response to this question.

7.3	How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

HMS does not have a response to this question.

7.4	How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

HMS does not have a response to this question.

8. GRIEVANCES AND APPEALS

8.1	How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

HMS does not have a response to this question.

8.2	How can the state and MCOs use appeals data to improve utilization management and access?

HMS does not have a response to this question.

9. ADMINISTRATIVE REQUIREMENTS

9.1 How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data do require?

OHCA and MCOs can streamline the data sharing by getting interoperability, which is a big ask. But it is the path other states are pushing. Obtaining the data to address member care should not be restricted. Getting full access to the data is a huge plus for running analytics to determine the next best action. As for patient privacy and security, it is critical to have these tenants in the solution you choose; all data must be protected, even the masked data. The more you know about the member/patient, the better you can serve them.

9.2 What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

The barriers to data sharing are numerous. However, the right incentives to help the providers comply will help move them in the right direction. In some states, Health Information Exchanges are used to house the data for the health plans to access. Other states are moving to an interoperability model.

Short of a state mandate that requires data sharing, the use of other data aggregation tools may be the best answer in the short run.

9.3 How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

MCOs can identify fraud with the right tools and methodologies. Several states have adopted a single tool for all MCOs to leverage to minimize fraud across the state. This model is highly effective at the MCO level as it brings better, more comprehensive data to be analyzed. The tool by itself is very helpful however, leveraging a Fraud/SIU team to do the review is critical. The Fraud/SIU can be at the MCO level and tool across all health plans.

HMS' FraudCapture tool is an industry leading tool that provides this solution. Our Fraud/SIU can help Oklahoma see the benefit and minimize fraud in Oklahoma.

9.4 Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

HMS does not have a response to this question.

Humana, Inc. (Humana) is pleased to submit our response to the Oklahoma Health Care Authority (OHCA) for Request 80720200002. Within this document, we share our insights and best practices as Oklahoma transitions to managed care with the goal of improving health outcomes, increasing access to care, and increasing system accountability within Oklahoma's Medicaid program, SoonerCare. Humana is deeply committed to serving the State of Oklahoma and its residents; with over 54,400 members, we are the second-largest Medicare Advantage (MA) plan in the state by membership. Humana covers every corner of the state as the only MA plan serving all 77 Oklahoma counties, including nine counties (Beaver, Cimarron, Ellis, Greer, Harmon, Harper, Roger Mills, Texas, and Washita) where we are the only private insurer offering Medicare plans. This year, we were proud to strengthen our relationship with the state by contracting with the Oklahoma Office of Management and Enterprise Services to offer Medicare Advantage coverage to eligible former state employees. In 2021, we are seeking to extend our commitment by filing to offer a Dual-Eligible Special Needs Plan (D-SNP) product for members eligible for both Medicare and Medicaid. In addition to medical coverage, we provide prescription drug coverage to over 61,000 Oklahomans through the Medicare Part D program. Finally, we are proud to cover over 156,000 US Military service members and their loved ones as the state's sole TRICARE plan.

Nationally, Humana serves members through Medicaid Managed Care (MMC) programs, Medicaid Managed Long-Term Services and Supports (MLTSS) programs, Centers for Medicare and Medicaid Services (CMS) Financial Alignment Initiative Dual Demonstrations, MA plans, D-SNPs, and Prescription Drug Plans (PDPs). Humana has served Medicaid populations continuously for more than two decades and currently manages Medicaid benefits for more than 689,000 members, which we expect to increase following our recent Medicaid award in Kentucky. Our perspective in this response is informed by leading practices grounded in:

- Significant experience with an integrated, person-centered model of care and commitment to the integration of physical health, behavioral health (BH), and long-term services and supports (LTSS) to positively impact health and social outcomes
- Expertise providing care management, care planning, and specialized clinical management to meet the complex needs of Temporary Assistance for Needy Families (TANF); Children's Health Insurance Program (CHIP); Medicaid expansion; aged, blind, and disabled (ABD); and dual eligible populations within a social supports-based framework
- Our position as a nationally recognized industry leader in establishing value-based payment (VBP) programs, with more than 30 years of experience and more than 52,000 Primary Care Providers (PCPs) in value-based agreements across 43 states

As a health, and well-being company that strives to offer person-centered, integrated care we are committed as a partner to states and communities in improving equitable health outcomes. We believe that this partnership must be reflected through our services and supports for members and provider networks, and through our commitment to our associates and communities. Humana has invested in the development of an organizational culture designed to give associates a sense of security, purpose, and belonging. We aim to inspire and empower our associates to help others, leading to an organization with superior associate engagement. Humana pays all associates at least $15 per hour, providing a sense of economic security and personal empowerment. We are proud to have earned the following honors that demonstrate commitment to good corporate citizenship:

- #4 on JUST Capital and Robert Wood Johnson Foundation's Top 100 Companies Supporting Healthy Communities and Families
- #1 in Customer Service among Health Insurance Companies by Newsweek for the second consecutive year in 2020

- #1 Health Care Provider in Forbes's "The Just 100: America's Best Corporate Citizens" for three consecutive years
- #2 in Health Care: Insurance and Managed Care in Fortune's "World's Most Admired Companies"
- 100% on Human Rights Campaign's Corporate Equality Index for six consecutive years

We are also dedicated to building healthier communities within the states we serve, because we understand how deeply the communities in which we live influence our health and wellness. **In 2015, Humana established an enterprise-wide population health strategy, our Bold Goal, to improve the health of the communities we serve through innovative partnerships with providers, local community-based organizations (CBO), businesses, and government agencies**. By co-creating sustainable solutions at a local level, Humana's Bold Goal seeks to meet members where they are to improve their well-being and quality of life. Our hard work has led to positive trends in low-income Humana members, who experienced a 2.9% reduction in Unhealthy Days in 2018.

Finally, we are deeply committed to being there for our state partners and communities through unexpected events and emergencies. We have worked closely with our state partners and community leaders to assist during hurricanes and other natural disasters, adjusting prior authorization procedures, and ensuring critical functions (e.g., call centers, care management, provider support, etc.) are available throughout the emergency and recovery periods. We understand the challenges OHCA faces during the COVID-19 pandemic, and the uncertainty this creates as you support members, providers, and your community. We have worked tirelessly with our state partners to reduce the burden of care for our members during COVID-19. This included waiving preauthorization requirements, the telehealth cost share, and all member costs related to covered testing and treatment. We are proud to have been the first insurer to offer our members LabCorp® at-home COVID-19 test kits and drive-thru COVID-19 testing at hundreds of Walmart Neighborhood Market pharmacies.[1] We also took critical measures to protect our most vulnerable Medicaid members, such as LTSS members, by increasing home meal deliveries, ensuring a 30-day supply of vital medications and nutrition, and supporting the transition of many from Adult Day Health Services to in-home services. For frontline responders and providers nationwide, we offer flexibility and support, expedite claims payments, reduce administrative burdens, and advance working capital for high-need providers.

[1] https://www.humana.com/coronavirus/covid19-humana-member-resources

Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid
- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting
- MCOs will serve members across the state

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

Questions for Stakeholder Input: Enrollees

1 **How and when should OHCA transition ABD and other initially excluded individuals to managed care?**

We suggest OHCA allow sufficient time for the agency, managed care organizations (MCOs), providers, and other stakeholders to establish strong partnerships and an operational foundation in Medicaid managed care prior to the transition of complex populations. Based on our experience serving ABD members in Florida, Kentucky, and Illinois, including transitioning Medicaid populations from fee-for-service (FFS) to Managed Care, Humana suggests transitioning initially excluded populations beginning in the third year of a managed care program. This timeframe would allow for OHCA, MCOs, and providers to establish both a strong baseline relationship and the capabilities needed to effectively implement managed care prior to taking on more complex populations. A strong foundation of partnerships with communities, OHCA, and other state programs will also help MCOs establish care management processes geared towards the needs of the state and the communities they serve. These partnerships and tailored care management models are a critical component for person-centered care planning, which is essential for successful management of high-risk populations.

To the extent possible, we recommend the plan and timeline for the transition of excluded populations be clearly structured and known from the beginning of the contract period. This provides an opportunity for MCOs to invest meaningfully in preparation for managing these populations and allows enough time for development of tools, staffing plans, and processes needed for a smooth transition to managed care. As part of the transition plan, we suggest including metrics and benchmarks to be met before and during the transition. Relevant metrics of MCO success include those mentioned in our response to **Quality and Accountability Q2** as well as goals for the transition itself, such as percentage of care plans completed. Examples of suggested process metrics include the number of community partnerships established, and

champions identified within legislative and stakeholder communities. We also suggest establishing a clear communication strategy among all stakeholders to create an open and transparent environment for success. An effective communication strategy includes conversations with OHCA, MCOs, providers, members, and all relevant stakeholders to understand concerns and discuss program design and operational issues.

We also suggest that OHCA establish contracts that allow for three years of continual enrollment of members previously excluded from managed care before going to reprocurement for these populations. This will allow sufficient time for MCOs to establish consistency, continuity of care, and to build trust with members, which are critical for success of the managed care arrangements.

2	**Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?**

We recognize that certain populations with complex needs, including children in foster care, American Indians/Alaska Natives (AI/AN), and people with Serious Mental Illness (SMI), require enhanced coordination and support across systems. Humana has extensive experience covering Medicaid members within all of these specific populations, as well as additional high-need populations such as dual eligibles, and individuals with LTSS needs (both institutional and community-based). Based on our experience in other states, we suggest that OHCA require each MCO to serve all populations in managed care they as long as the MCO demonstrates the ability to deliver person-centered services and effectively coordinate across systems, as described in our responses to the **Benefits, Quality and Accountability, and Care Management and Coordination** sections of this response. Requiring MCOs to cover all populations would minimize further fragmentation in offerings which may be challenging for members (who could experience splits in coverage across families), providers (who would experience additional billing complexity), and other stakeholders to navigate, and create additional oversight burden for OHCA. Our recommendations on strategies that MCOs should use to coordinate services for these populations are described in our response to **Care Management and Coordination Q5**.

3	**How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?**

MCOs can empower members to engage in healthy behaviors by creating person-centered care plans and programs that incentivize behavior change and self-management, utilizing community relationships and knowledge in care planning and member services, and the use of technology and social media when available and appropriate. MCOs should strive to discern what resonates with and drives their members to act in support of themselves. For example, at Humana, we leverage tools from behavioral economics to change behavior, recognizing that some of the largest barriers to individual health and well-being can involve financial burdens, social biases, and decision complexity. Focusing on tools to address those barriers, such as simplifying decisions and decreasing transaction costs, are keys to improving health outcomes. Financial incentives can promote wellness activities and care plan adherence among members; however, MCOs should also build interventions focusing on habit formation so healthy behaviors persist even after the incentive has gone away.

To drive healthy behaviors, Humana uses a person-centered approach to wellness. This means meeting members where they are and taking a strengths-based approach to help them make healthy choices. It also entails a seamless experience across providers, communication channels, technology solutions, and programs that make it easier to engage in care and wellness activities. As a best practice in encouraging members to see a doctor regularly, we suggest building a foundation of healthy behaviors through targeted, culturally competent member education, and incentives for completing certain doctor visits and/or health goals. In addition, MCOs can leverage disruptive events, such as a hospitalization, as an opportunity to educate members on specific healthy behaviors to drive wellness, as well as an opportunity to connect members to a PCP. As part of person-centered care, MCOs should also help members identify and address social determinants of health (SDOH) that may get in the way of healthy behaviors. For example, MCOs can help address transportation barriers that prevent members from seeking preventive care or taking part in healthy activities, or help members make healthier eating choices by addressing food insecurity. MCO strategies to address SDOH are covered further in our response to **Benefits Q2**. Some members benefit from more intensive engagement and should receive ongoing support from a Care Management team trained in motivational interviewing to identify member strengths while removing barriers to healthy behaviors.

To encourage members' healthy behaviors – such as seeking regular preventive care, quitting smoking, and eating healthier – MCOs can:

- Conduct targeted, culturally competent member education
- Offer incentives for the completion of certain doctor visits and/or health goals
- Identify and address SDOH barriers to healthy behaviors, such as lack of transportation and/or food insecurity
- Develop strong partnerships with community organizations who know members
- Leverage CHWs to help guide members to making healthier choices
- Empower members to manage their own health through digital wellness solutions
- Conduct provider training to ensure providers are delivering culturally competent care

The source of the messaging about healthy behaviors is also critical. In communities where MCOs see particular challenges or barriers to healthy behaviors, we believe that MCOs should employ community health workers (CHWs) who are trusted members of the community to deliver this message. CHWs can leverage their standing in the community to build enduring relationships with members, providers, and community-based organizations; facilitate access to services and resources (especially related to BH or SDOH); and support health promotion and cultural fluency. CHWs help members navigate community resources and make healthier choices in the context of their community and home environment. In addition, CHWs can attend appointments with members who may have distrust of the health care system or low health literacy and serve as champions and advocates to help empower members over time. CHWs can also assist providers to develop culturally appropriate educational materials and clinical documents.

Community partnerships similarly provide an important resource to create culturally appropriate, person-centered approaches. We recommend that MCOs form relationships with trusted community organizations working to improve health and wellness in communities and collaborate with them to both advance programming and connect members to services. Examples of strong on-the-ground organizations that should be considered as potential MCO partners in Oklahoma include the Tobacco Settlement and Endowment Trust, Shape Your Future OK, and the Turning Point Coalition. These organizations are already working on the ground to advance healthy behaviors in communities across Oklahoma and should be employed by MCOs for their expertise and because of the deployment of

proven programs in the state. Other research and system support organizations like the Oklahoma State University (OSU) Center for Health System Innovation, OSU College of Osteopathic Medicine – Rural Health Center, the Health Promotion Research Center (formerly Oklahoma Tobacco Research Center) and others can provide additional Oklahoma-specific guidance to MCOs to influence healthy behaviors.

Outside of their direct work with CBOs and CHWs, MCOs should strive to increase cultural fluency and competency among healthcare professionals in terms of their engagement with community members about healthy behavior. Cultural education for healthcare professionals in particular is an important component of improving providers' relationships with diverse patient populations and can help in addressing racial/ethnic disparities in health. MCOs' provider support model should include training for providers and their staff in an easily accessible format available at times convenient for them. We also recommend that OHCA and MCOs partner with leading organizations to give providers access to trainings on cultural fluency, adverse childhood experiences (ACEs), and trauma-informed care (TIC).

MCOs can emphasize health equity and cultural fluency among their staff and their provider networks, breaking down implicit bias through robust training and education. As such, cultural fluency should be an integral component of the actual organizational culture for each MCO. For example, Humana requires associates who serve Medicaid members to complete supplementary training tailored to this population, including topics such as health literacy and numeracy, cross-cultural negotiation, and understanding individuals. Additional strategies related to training, the use of culturally fluent materials, as well as methods of bridging language barriers are discussed in **Member Services Q2**.

MCOs can use technology as another avenue to empower and educate members, provide digital tools and solutions to align with members' physical and behavioral health needs, and build community around an expanded ecosystem of services that members can access in their preferred setting. Although the pace of digital innovation for individuals on Medicaid lags the rest of the healthcare industry, Medicaid members have an appetite for using technology to help improve health and wellness.[2] Social media also creates powerful online communities that MCOs can harness to educate members and the broader community on important health and wellness-related topics. Campaigns can be focused on priority population health areas such as maternal health or on emerging public health priorities, such as COVID-19 and the flu. We will discuss these opportunities more in our response to **Member Services Q3**.

While technology and social media can provide good mediums of connection, not everyone will have reliable access to technology. As a result, we offer detailed recommendations to increase access to technology in **Member Services Q4** as well as other methods of conducting outreach in **Member Services Q3**.

Benefits Provided Through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

[2] https://www2.deloitte.com/content/dam/insights/us/articles/4673_Medicaid-and-digital-health/DI_Medicaid-and-digital-health.pdf

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers

Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

1	**What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?**

Several factors impact access to care, including: cultural, socioeconomic and geographical barriers (e.g., SDOH), and a lack of available medical professionals. For both the initial population transitioned to managed care as well as the groups with complex needs transitioned later, MCOs must apply a person-centered approach to mitigate barriers to care that are also rooted in the context of members' communities and culture.

To address access challenges within other Medicaid markets, Humana employs health strategies that include member support mechanisms, partnerships with communities, digital solutions, and increased provider capacity. There are additional strategies related to expanding access to behavioral health services, which we will describe more in our response to **Benefits Q4**.

Member Support — Members may face complex challenges that affect their ability to access care ranging from navigating information about what services are available to them in-network, to overcoming barriers related to SDOH that prevent or delay seeking treatment or getting to appointments. MCO member services are the eyes and ears of an organization and should internally communicate members' needs in real time in order to mobilize the right groups to help remove barriers to care. MCOs should make information available 24 hours a day and 365 days a year and create easy ways for members to self-serve information through member portals – such as easily searchable provider directories. Member services and care management personnel can help identify nearby providers and call to schedule appointments on a member's behalf. Member care plans should include assessments for barriers to access and collaborative planning with all providers and support services to overcome these barriers. MCOs can also hire CHWs to help members navigate their health care needs

and to help build trust in the health care system thanks to CHWs' deep understanding of members' social and cultural context.

Partnering with Communities — For certain populations, we recommend that MCOs build community partnerships to improve access. For example, with Oklahoma's unique and large American Indian population, close relationships with tribes, tribal health systems, and Indian Health Services will be essential to addressing access for this population. Bringing care directly to members is an important and effective approach to improving access for members living in rural areas or health professional shortage areas (HPSAs). MCOs could develop and leverage partnerships with established organizations to host pop-up clinics, or work with CBOs and Federally Qualified Health Centers (FQHCs) to bring care directly to members using mobile medical vans. We have also partnered with schools, community centers, and churches to bring care directly to members.

Developing Telemedicine and Mobile Health Solutions — Of Oklahoma's 77 counties, 72 are designated as a HPSA, with four additional partial HPSAs. Seventy-two counties are designated as mental health HPSAs. These designations indicate access to care is limited by availability of providers in the area. In addition to the provider shortage, factors associated with the current COVID-19 pandemic have increased the barriers to care and treatment. Telemedicine and digitally enabled programs such as community paramedicine, crisis consult and support, and models that enable provider-to-provider consults and training can help increase access points to healthcare delivery. Humana also employs digital health solutions such as mobile applications to support provider capacity by enhancing our remote monitoring and the use of physician extenders to improve capacity to members.

As OHCA looks to the future, there is opportunity to develop partnerships to enable investment in provider platforms and broadband access to support these access points. In other states, Humana committed to overcoming the broadband hurdle by leveraging federal dollars and programs in conjunction with private funding and partnerships. For example, Humana came together with the Older Adults Technology Services (OATS) to support increased access to internet connectivity, devices, and training as measures for seniors to decrease social isolation and improve health and well-being.

Increasing Medical Professional Capacity — Humana invests in the medical professional pipeline and recruitment of providers to address provider shortages and access to care, which is discussed in more detail in later in the **Network Adequacy Q3** response. It will be important for OHCA and the state to review the scope of practice for mid-level providers to begin to fill some of the gaps in delivering care and reserving MDs and DOs for the provision of more complex medical care. It will also be important for OHCA and MCOs to monitor provider competencies and incentivize the inclusion of this information into provider directories to better connect both members and referring providers to specialized care. More detail concerning the use of provider directories to connect members to care is included in the response to **Member Services Q6**. Finally, VBP arrangements can increase Medicaid provider capacity by rewarding high-performing providers with rates/earnings well above the Medicaid fee schedule, which encourages more providers to accept Medicaid patients.

2	**What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?**

Humana strongly supports the integration of services to improve outcomes and access for SoonerCare members and believes that the transition to managed care can help to further integrate and coordinate services, as well as enhance the level of covered benefits. We recommend the following strategies for OHCA's consideration:

Shared Assessments and Person-Centered Planning — For individuals with complex care needs, we believe that using Multidisciplinary Care teams (MDTs) with regular meetings is an important way to improve communication and collaboration across providers and care managers for person-centered care planning and coordinated care (further detail is provided in our response to **Care Management and Care Coordination Q4**). In addition, OHCA could consider including standardized assessments and greater incentives beyond the SoonerExcel quality payments for the Patient-Centered Medical Home (PCMH) program and PCPs in SoonerCare to screen individuals for BH and SDOH needs. We further describe our approach in our response to **Benefits Q3** and **Benefits Q4**. By incentivizing screening and warm handoffs in certain VBP arrangements and providing PCP education, we have seen an increase in screening and follow-up treatment for patients presenting with BH needs. However, if requiring or incentivizing screening, we suggest that OHCA facilitate a forum to create consistent screening and education materials across MCOs to minimize differing guidance for providers.

Financial Incentives for Co-Location and Coordination — We suggest that MCOs use incentives to promote co-location of BH providers within a primary care setting as well as PCPs within a BH setting. For example: Humana's PCPs have access to a Practice Transformation Incentive, which they may use to add staff to service the BH needs of members, invest in telehealth equipment that could be used to virtually connect members with BH services, or to employ a patient navigator or social worker who could assist with navigating across physical health, BH, and SDOH-related needs. For BH providers, our VBP program includes a referral bonus for successfully encouraging members to see their PCP. Similar overlaps and incentives could be built into the Oklahoma Patient Centered Medical Home and Behavioral Health Home (BHH) model. MCOs may also incentivize providers to screen for SDOH using a standardized screening tool or to use ICD-10 Z codes to identify SDOH needs, which MCOs can then use to trigger additional member support and coordination, as discussed in our response to **Benefits Q3**.

Provider Education and Support — In our experience, provider training and knowledge-sharing forums are an important component of integrating care, and we suggest that OHCA look for this as a best practice among MCOs. For example, Humana is working to implement Practice Innovation Advisors in each market to focus on assisting providers as they become a Health Home or develop strategies for improved physical, BH, and SDOH integration. The Practice Innovation Advisor reviews data with providers to help identify education needs, including trainings on Screening, Brief Intervention, and Referral to Treatment (SBIRT), and supports the practice in negotiating data-sharing agreements with other providers. Humana's Practice Innovation Advisors can help practices establish standardized referral agreements between physical health and BH providers, as well as joint care teams, to simplify and expedite referrals and establish best practices for warm handoffs.

Provider Communication and Data Sharing — Seamless, real-time data sharing is also an important step to deliver holistic integrated care. OHCA could instruct MCOs to participate in the future statewide Oklahoma Health Information Exchange (HIE) to help improve continuity of care and the exchange of member data across plans and with providers using best practices such as HL7 data standards and the Fast Healthcare Interoperability Resources (FHIR) interoperability specifications. This bidirectional sharing between payer and provider enabled by the HIE ensures all healthcare providers can quickly and easily access appropriate clinical data details, as well as assist the state with public health activities, such as syndromic surveillance. Coordination between PCPs and BH providers is often lacking, and we believe that MCOs should facilitate a relationship by working with BH providers to provide quarterly updates on the members they serve to share with PCPs. MCOs could assist BH providers with electronic health records (EHRs) adoption in partnership with OHCA and potentially the state's HIE when operational. It is also critical to have a process to collect member consent to share BH data across PCPs and MCOs,

removing one of the top barriers to coordination and integration. OHCA could consider creating a comprehensive consent form that accounts for specially protected health information to help facilitate BH data sharing, similar to the one developed by New York to share information on members in Health Homes.[3]

Technology offers valuable opportunities to integrate care digitally. For example, peer-to-peer teleconsultation with a psychiatrist can be incredibly valuable for PCPs who may not have a lot of experience treating behavioral health needs, particularly in a pediatric setting. Project ECHO™-like models for peer-to-peer education can also be an important way to educate and build confidence for providers new to delivering integrated services.

3	**How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?**

We suggest OHCA explore the following best practices for MCOs to facilitate referrals and track the outcome of referrals to social services, and support member needs related to SDOH. Our recommendations align with leading practices that have emerged around the United States.[4]

Identifying SDOH — The first step to effectively connecting SoonerCare members to social services is understanding each member's needs. MCOs should integrate social needs screenings into member assessments, both during initial health needs assessment screenings and comprehensive care management assessments. To ensure consistency of data, we recommend a standardized set of screening questions across MCOs, such as the Route 66 Consortium Accountable Health Community (AHC) Screening tool. Standardization can allow for analysis of specific needs at the total population level and inform both public policy decisions as well as public and private investment. MCOs can also integrate SDOH factors into their risk stratification methods by incorporating SDOH data, clinical outcomes data, environmental and geographic-level data, and consumer data. MCOs may incentivize providers to screen for SDOH using a standardized screening tool, providing technical assistance on integrating social risk factor tools into EHRs, and training them on how to correctly use ICD-10 Z codes so that SDOH can be identified from claims data.

Effective Navigation — Navigating social services can be complex and it is important for the MCO to include individuals with a deep understanding of local communities and the social services infrastructure. For example, Humana hires CHWs from the communities in which our members live and who possess a strong understanding of the community organizations in their region. These CHWs are often critical to assisting members with referrals and coordination with local organizations. In addition, we have designed models that include SDOH coordinators, who are responsible for establishing and maintaining relationships with local CBOs and communicating details to the rest of the Humana Care Management team to ensure appropriate access to needed services, as well as directly supporting members who are not engaged in care management but have urgent SDOH needs. These relationships and the cultural awareness that results from them will be especially important when serving Oklahoma's rural populations, who experience different local challenges and access to resources that may require creative solutions, as well as with tribal members and engaging each tribe's established social service programs. SDOH coordinators will also play a key role in linking local efforts to address SDOH with

[3] https://www.health.ny.gov/forms/doh-5055.pdf
[4] https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/

statewide priorities and plan-wide initiatives. Our Housing Specialists use existing pathways and resources available within the state and through other agencies such as Housing and Urban Development (HUD)/Housing Finance Agencies, local housing authorities, and Continuum of Care Agencies. Additionally, a resource directory or referral platform (discussed in the following paragraph) can be made available directly to members and assistance personnel to provide connections to a comprehensive set of health-related social services from local CBOs.

Referrals and Coordination — SDOH resource and referral platforms are rapidly becoming a standard practice to match individuals with social needs to resources in their community and track the outcomes of referrals. Many MCOs are partnering with vendors, while some states are procuring statewide referral platforms such as NCCARE360 (a partnership led by North Carolina DHHS). Regardless of whether a state selects a single platform or not, we suggest as a best practice that these platforms be integrated with MCO care management systems and provider EHRs, and accessible, at no cost, to CBO partners. Given the proliferation of resource and referral platforms, it is important to note that CBOs will not want to use multiple platforms to receive and track referrals and sometimes already have a system of record they utilize. As a result, any solution chosen should fit the needs and capabilities of CBOs. Adoption of a single closed-loop solution can help ensure that payers, providers, community organizations, and state agencies all share an up-to-date listing of available resources, understand what referrals have been made, what follow ups are needed, what services have been delivered, and can track outcomes even as members move between plans.

Partnering with Communities — As MCOs help members address social needs through referrals to CBOs, MCOs must also come to the table as partners who can help communities build their capacity to provide services. In addition to support with technology, grants, and volunteering, Humana is a proponent of pay-for-success models that help CBOs maintain sustainable financing while promoting accountability. CBOs may need support as they learn to bill for services, which may require additional technical assistance from MCOs. While we recommend a collaborative approach, MCOs can also offer their own set of services, particularly in areas where the network of social service providers and resources may not be enough to meet member needs. For example, MCOs are buying housing stock in areas without affordable housing to provide temporary and supportive housing, and some offer their own meal delivery in food deserts. Additionally, MCOs can use value-added benefits – from reimbursing for nonemergency transportation to reimbursing for criminal record expunging – to reduce barriers to employment and housing. Finally, MCOs can serve as partners for the state and for communities in finding creative solutions for new or braided funding streams to fill gaps in the needs of communities to solve for complex issues such as homelessness.[5]

Measuring MCO Performance — Ultimately, success in addressing SDOH should be measured through population-level measures that reflect efficient, whole-person care such as access to care, potentially preventable events, member experience, or CDC Healthy Days which are described in our response to **Quality and Accountability Q2**. Over time, effectively addressing SDOH should also be reflected in cost and utilization measures such as hospital readmission and the total cost of care. However, we also recommend that in the early stages of implementing the new managed care model, that OHCA track process metrics such as the number of members screened for SDOH, the percentage of members who screen positive for social needs and are referred to community resources, and even the outcomes of these referrals – ideally using a platform such as the one described earlier in this response. OHCA could also consider designing incentive programs with MCOs to help target priority SDOH areas in the state

[5] https://housing-futures.org/2019/03/09/arizonas-medicaid-system-is-fighting-homelessness/

while also increasing collaboration and alignment across payers (e.g., collaborating for regional improvement in food insecurity).

4	**How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?**

MCOs can play a central role in equipping providers with the appropriate training, support network, and resources to be able to both readily access and properly apply evidence-based practices for BH needs such as such as substance use disorder (SUD). As SUD-related illness and injury have increased during COVID-19, it is even more important for MCOs to empower providers and equip them with the resources to identify and treat members' BH needs.[6] MCOs should look to gain deeper understanding of barriers to evidence-based BH care in Oklahoma from existing programs like the ODMHSAS SBIRTOK program, which is supporting providers across the state to execute SBIRT in different care settings.

Increasing providers' ability to effectively apply practices such as SBIRT is often the first step to increasing access to care. We suggest that OHCA ask MCOs to convene joint educational sessions, such as webinars and town halls, to educate providers regarding clinical criteria, and facilitate provider-to-provider mentorship to improve the application of these techniques. This is especially important as more PCPs integrate BH services into their practices and/or deliver medication assisted treatment (MAT) services to improve integrated care.

As forms of BH evidence-based care like High Fidelity Wraparound services or assertive community treatment are incredibly resource intensive and no more effective than traditional models when inaccurately applied, OHCA should work with MCOs to provide guidelines outlining access to BH services at the appropriate level of care so that interventions occur when appropriate.[7] These guidelines should include an independent process for reviewing level of care determinations and specific details as to how such a review would occur. We recommend that these are developed in a manner that enables all MCOs' decision criteria to be compared with the recommendations generated by evidence-based assessment tools approved at the state level. We also strongly support a policy of no prior authorization for preferred providers offering MAT in office-based settings. However, OHCA may wish to balance this with an approach similar to MassHealth's policy for dose-based prior authorization for buprenorphine and naloxone for opioid use disorder (OUD) treatment, which removed prior authorization for dosages within the U.S. Food and Drug Administration's recommendations and required, more frequent prior authorization as prescribed dosages increased. This approach was successful in reducing the number of individuals receiving higher than the recommended dosage.[8]

Because stigma may be a barrier in providing services to individuals with SUD, we also suggest that OHCA consider launching an anti-stigma campaign associated with SUD prevention, treatment, and recovery. In addition, provider mentorship is a key factor to reduce stigma and increase the knowledgeable application of evidence-based practices. OHCA may consider a model to provide free consultation service for PCPs similar to the Massachusetts Consultation Service for Treatment of Addiction and Pain (MCSTAP). MCSTAP helps PCPs integrate evidence-based practices for screening, diagnosing, treating, and managing chronic pain and/or SUD into their practices. The service allows providers to call during business hours, receive a consultation within 30 minutes, and speak to resource and referral specialists if they need information on community-based resources. OHCA should also

[6] https://www.aamc.org/news-insights/covid-19-and-opioid-crisis-when-pandemic-and-epidemic-collide
[7] https://nwi.pdx.edu/pdf/Effectiveness-of-Wraparound-vs-case-management.pdf
[8] https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.12201

consider a peer support program, such as that developed by Virginia. In Virginia's model, regional MAT Champions serve as mentors to new MAT providers in their areas and provide advice about difficult cases. As a result, the number of members who received pharmacotherapy increased by 34% during the first year of implementation.[9] More generally, Oklahoma's successful use of Peer Recovery Support Services should be carried through to the managed care environment, and MCOs should look for opportunities to build on and expand access to the state's current peer support infrastructure.

OHCA could also work in partnership with MCOs to leverage the state's institutions of higher education, Oklahoma State University and their National Center for Wellness & Recovery, to develop a Center of Excellence to disseminate best practices for BH or SUD care, including pharmacotherapy, behavioral therapy, and Assertive Community Treatment (ACT). Developing or strengthening partnerships between universities and colleges, including community colleges, could further facilitate multidisciplinary dissemination and ensure future clinicians and other healthcare professionals are well-versed in this model.

Tying back to our response to **Benefits Q1**, technology again offers valuable opportunities to expand provider knowledge and understanding of evidence-based behavioral health. For example, the Project ECHO model referenced before exemplifies an invaluable support mechanism for PCPs who may not have a lot of experience treating BH needs, particularly in a pediatric setting. Project ECHO-like models for peer-to-peer education can also be an important way to educate and build confidence for providers to execute on evidence-based behavioral health interventions and therapies.

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as state priorities: **tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**
- MCOs will reimburse **providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions
- **OHCA is investigating the use of incentive measures, quality pools and other programs**; MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

2	**What are the most important indicators of MCO performance? Why?**

MCO performance should be evaluated based on their success in providing access to clinically appropriate care and effective care coordination, providing a positive member and provider experience, and improving population health outcomes – all while providing value for the Medicaid program by reducing preventable costs. We suggest that, when possible, metrics be aligned with national standards

[9] http://www.tacinc.org/media/90793/arnold-foundation-brief-expanding-mat_may-2019v02.pdf

such as the National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness Data and Information Set (HEDIS®), those in the CMS core set, and those endorsed by the National Quality Forum (NQF). We also suggest that all metrics tracked to indicate MCO performance be measured year over year to track improvement relative to baseline, and also benchmarked against state averages as well as national data. OHCA could also look at disparities in metrics within each MCO's membership based on characteristics such as race, language, ethnicity, and geography.

Improving Population Health Outcomes — A variety of health plan performance measure sets, including the commonly used HEDIS, include outcome measures such as readmissions and preventable hospitalizations. The outcome measures OHCA chooses to use to assess MCO performance should align to its population health priorities as well as the measures it uses to evaluate provider performance. For example, if OHCA is prioritizing maternal and child health, plans should be evaluated and reimbursed based on preventable C-sections, preterm/low-weight births, and similar outcomes. OHCA could also consider the use of new measures that are focused on whole-person health and population health, such as CDC's Healthy Days. Healthy Days began as a set of survey measures developed by the CDC and its partners for use in tracking population health status and health-related quality of life (HRQOL) in states and communities. In recent years, several organizations have found Healthy Days measures useful at the national level for identifying health disparities, tracking population trends, and building broad coalitions around a measure of population health. We use this metric to set and evaluate our Bold Goal of improving the health of communities we serve by creating evidence-based, scalable, and financially sustainable solutions with community partners and provider practices. The Healthy Days metric shows a direct link between improved health, positive business results, and social impact, and could be considered as a pilot measure to gauge the impact of SoonerCare population health activities in targeted communities.

Process Measures — Process measures can reflect whether an MCO's population is receiving interventions to maintain or improve their health, and whether there are gaps in adherence to clinical guidelines that should be addressed. For example, metrics that indicate the percentage of membership receiving preventive care as well as rates of pediatric immunizations and adult cancer screenings can provide valuable insights into access to care and member engagement. We also advocate for use of metrics that consider sociodemographic and demographic patient factors in order to promote health equity. We recommend that OHCA consider the 35 disparity-sensitive measures that have been endorsed by the NQF.

Process measures can also be used to measure the effectiveness of an MCO care management program. For example, OHCA could track the percentage of high-risk members who are enrolled in care management, the duration that members stay engaged, the frequency of member communication, and whether members in care management have improved quality metrics, cost, utilization, and outcomes relative to a similar cohort that is not care managed.

Member and Provider Experience — One of the best tools to measure MCO performance regarding member experience is Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which capture member experience through broad metrics, such as Overall Plan Rating, and more detailed metrics, such as appointment wait times. Mandated CAHPS surveys are administered once annually, but we believe in monitoring member experience throughout the year, so we have invested in simulation CAHPS surveys to proactively identify and address issues related to member experience throughout the year. Another member experience metric, the Net Promoter Score (NPS) index, measures the willingness of customers to recommend a company's products or services to others across five evaluation criteria: quality of communication, professional competence, range of services, customer

focus, and accessibility. Provider satisfaction can also be measured either through a standardized survey created by OHCA, or by MCO surveys of their provider networks.

Reducing Preventable Events — Standardized measures of potentially preventable events, such as 3M's grouping software for potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room (ER) visits, create a comparable view of performance across MCOs, hospitals, and providers to identify variance in performance and inform payment models.

We provide additional detail on specific metrics to measure health outcomes and member experience of care in our response to **Quality and Accountability Q3** below and **Member Services Q1**.

3 What measures of health outcomes should be tracked?

Humana strongly supports the use of outcome measures to evaluate MCO and provider performance, in addition to the traditional focus on structural and process metrics. We see outcome metrics as key components of driving improved quality and value, further incorporation of population health management into general care, and increased patient engagement. We recommend that metrics chosen include Utilization-based Outcomes (such as all-cause readmissions as defined by NQF), as well as outcome metrics aligned to specific population health priorities.

We also suggest OHCA establish alignment between metrics they hold MCOs accountable for and those that MCOs use in their VBP models. As the shift to outcome measurements in the Oklahoma Medicaid program will be a shift for providers who will need to share more clinical data, Humana suggests adding these types of measures over time, and as VBP models take on increasing risk and complexity (e.g., removing medication management for people with asthma and adding Asthma Pediatric Quality Indicator, Asthma Admits per 1,000). This phased approach can help ensure providers are not placed at undue financial risk and allows time to work through any reporting and data collection challenges.

Based on OHCA's population health priorities, we offer the following select outcome metrics for consideration:

Infant Mortality and Pregnancy Outcomes:

- Live Births Weighing Less Than 2,500 Grams - (NQF #1382)
- Cesarean Birth - (NQF #0471)

Chronic Conditions:

- Comprehensive Diabetes Care: HbA1c Control (<8%) - (NQF #0575)
- Diabetes Short-Term Complications [Prevention Quality Indicator (PQI)-01) - (NQF #0272)
- Controlling High Blood Pressure - (NQF #0018, CMS165v8)

Behavioral Health:

- Depression Remission at 12 Months (Adolescents and Adults) – (NQF #0710, CMS159v8)

For certain OHCA priority population health conditions and populations, there are currently no widely used, endorsed outcome measures. In such cases, we have recommended NQF-endorsed process measures for initial consideration. We are eager to work with OHCA to evaluate or develop appropriate outcome measures for these important populations.

Tobacco Use:

- Tobacco Use: Screening and Cessation Intervention (NQF #0028)

Opioid-Related Overdose Deaths:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NQF #0004)

Childhood Obesity:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NQF #0024)

Behavioral Health Access:

- Screening for Clinical Depression and Follow-Up Plan (NQF #0418)
- Follow-Up After Hospitalization for Mental Illness (NQF #0576)

Care Management and Coordination

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- **Conduct health screenings** to identify ongoing need, current providers, and social determinants of health
- **Develop care plans** for identified enrollees and establish care management and care coordination based on identified risk and particular health conditions
- **Design health management programs** with a holistic approach to member health
- **Conduct health education** in priority areas and on emerging issues

In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

Questions for Stakeholder Input: Care Management and Coordination

3	**What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?**

To best meet SoonerCare members' BH needs, OHCA could consider the following approaches and best practices: Bolstering provider networks via telehealth; creation of fully integrated care plans; and development of provider delivery models for quality behavioral health services. MCOs should also be required to employ licensed BH professionals to manage members with complex BH needs. Following are high-level process and technology considerations:

Network Development

Virtual BH and Digital Solutions — Telebehavioral health can be an important avenue to improving access and advancing integration to BH services. We recommend that OHCA encourage MCOs to bring approaches such as telebehavioral health appointments from members originating at a PCP office, psychiatric/BH teleconsult for PCPs, and direct-to-consumer telebehavioral health solutions. Access to

evidence-based self-service digital tools and applications can also help bolster member's self-management of BH conditions.

Care Delivery

Co-Location of Services — To encourage physical and BH integration, OHCA could look to MCOs to provide financial and technical support for PCPs and/or BH providers to support co-location. For example, Humana has developed a one-time Practice Transformation Incentive, which network PCPs may use to add staff to service the BH needs of members. For BH providers, our VBP program includes a referral bonus for successfully encouraging members to see their PCP. Technical support can also promote co-location by guiding providers through the integration, with assistance on key operational topics such as how to bill for integrated services.

Behavioral Health Homes — We suggest that OHCA leverage and require close coordination between MCOs and ongoing initiatives such as the Oklahoma Behavioral Health Homes Initiative that joins physical and BH and offers enhanced coordination and comprehensive care management for SMI and serious emotional disturbance (SED) members. We agree with OHCA's position that BHHs have the potential to significantly improve outcomes and reduce avoidable costs, and that increasing ease of access to physical health services for members with BH diagnoses leads to overall improved health and well-being. MCOs can engage BH practices to determine their interest and evaluate their capabilities to incorporate the six services required by OHCA and use network management functions to help practices build the capabilities they need through practice coaching and incentive programs.

Multidisciplinary Team — We believe a Multidisciplinary team is key to providing coordinated, holistic, and person-centered care. While there are many ways teams can be structured, we recommend employment of Care Managers who are both registered nurses and social workers, as well as CHWs and Peer Support Specialists. The use of such a Multidisciplinary team with unique resources like the Peer Support Specialists or Peer Recovery Specialists who share valuable lived experiences with members can support engaging the member to meet their behavioral health needs.

Care Coordination

Fully Integrated and Shared Care Plans (with Member Consent) — We suggest that OHCA require a care plan development process that is person-centered and member-driven, with the support of the member's representative and other members of their chosen support system. The plan should consider members' physical health, BH, and SDOH services and needs. Upon care plan completion, we recommend that members and their representatives should be able to access the care plan via an MCO member portal, and providers (including their PCP, BH provider, and any specialty providers) should be able to share the care plan in a secure manner.

4	**How can MCOs improve the management and coordination for members with chronic or complex health conditions?**

OHCA has had great success managing certain SoonerCare members' chronic health needs through the Health Management Program (HMP). MCOs should build upon HMP's success and incorporate lessons learned through this program about the unique chronic health challenges of Oklahoma's SoonerCare population. Similar to HMP's use of integrated health coaches in PCP offices to expand the range of services available, we believe a MDT is key to improving the management of chronic and complex health needs. An integrated team is central to the development of fully integrated and shared care plans that account for member goals and consider their physical health, BH, and social needs. While there are

many ways in which care teams can be structured to efficiently and effectively deliver care management, we suggest employment of registered nurses, social workers, licensed BH professionals, SDOH coordinators (as discussed in **Benefits Q3**) as well as CHWs and Peer Recovery Specialists who share valuable lived experience with members. To be person-centric, this team should provide an integrated approach across MCO care managers/care team members and provider-based care managers. We recommend that OHCA provide specific guidelines on who is responsible for convening MDTs when both the MCO and provider have care managers. For example, Louisiana required that plans convene these meetings, unless the member had a care manager through their provider office.

Many Medicaid members, particularly those with complex needs, often have strong, established relationships with their care providers and it is important for MCOs to design a care management structure that can incorporate and support existing care management services. We suggest that OHCA require MCOs to demonstrate their ability to partner with provider-led care management, and to support provider-led care management capabilities through advancing value-based arrangements.

MCOs can also use hub-and-spoke models in conjunction with MDT to allow team members to meet with members in their preferred location in the community. This type of outreach can foster engagement and trust and lead to improved outcomes at lower costs. The hub-and-spoke model can be particularly effective in connecting with complex populations who may be difficult to reach or who do not traditionally engage with the healthcare system, such as members experiencing homelessness, members with SMI, and members who inject drugs. In rural areas, we have found that CHWs and community paramedicine programs can serve as critical extenders of the MCO Care Management team as well as a link to the health care system when needed. OHCA could encourage MCOs to test technology-enabled models to improve access to care and engagement of underserved members, such as technology-assisted peer support model for rural members with disabilities.

As digital solutions are a means to bolster member's self-management of complex conditions, MCOs should partner with vendors to provide members with free access to evidence-based digital solutions to care for chronic conditions. However, we recognize that digital solutions cannot work for all members and that even for some of those who would otherwise engage technology barriers may exist. OHCA can also look to MCOs to help address such barriers, as we will discuss in more detail in our response to **Member Services Q4**.

Members with complex needs often struggle with social isolation. Our research has demonstrated that social isolation has the greatest impact on Healthy Days, roughly equal to smoking 15 cigarettes a day, and is more impactful than obesity. This is particularly true for people with disabilities. MCOs can help address social isolation by ensuring timely and consistent provision of home-based services, by creating opportunities to engage members in their communities, and by engaging members digitally – particularly during COVID-19.

Caregiver supports are equally important to ensure those entrusted to caring for individuals with complex needs are also able to care for themselves. If members do not have reliable, healthy primary support at home through friends or family, those members are at a greater risk of hospitalization and re-admission. We link our members' caregivers with support groups, education, social support, and respite care (as a covered service or value-added service) to combat the social isolation and potential burnout often associated with caregiving. Digital tools can play an important part in helping caregivers manage resources, community supports, and the healthcare needs of their dependents; self-directed tools and

connection to the care team, as well as suggestions of caregiver supports, can provide a powerful level of guidance and support.

5	**What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?**

Community members in the AI/AN populations must often navigate multiple complex systems and experience fragmented service delivery, which in turn fosters a lack of trust in the health care system. To address this, we suggest that OHCA look to MCOs to play an important role in serving as a "quarterback" to coordinate care for populations with extremely complex needs who are served across multiple systems. This includes using a liaison model in which the MCO employs specific individuals to interface with various agencies, backed by a MDT with deep knowledge of health and human services systems, social services, and the physical and behavioral health delivery systems. In this model, each member has a point of contact through their care manager, as do the agencies working with the member and MCO, to aid in the coordination of services.

Overall, MCOs can help providers better engage and care for complex populations through offering provider training on cultural competency, implicit bias, and trauma-informed care (TIC). They should also develop a provider relations model that supports providers' efforts in ways that best meet their needs. For example, providers have different perspectives about the frequency of contact with MCO staff, the type or frequency of training, and the data that would best assist them in designing and implementing strategies to improve the member experience. Given provider time constraints, a coordinated approach to training across MCOs may be beneficial.

Challenges and recommendations specific to the populations mentioned by OHCA include the following:

Children in Protective Services or Foster Care — have experienced a unique form of trauma that requires a highly coordinated care management approach to be successfully treated. As these children move among homes, schools, providers, and social networks, their medical and social needs are often compounded in complexity. MCO care management approaches should therefore involve highly individualized care plans that involve a full range of providers as well as all appropriate family members and guardians. Plans should employ highly intensive case management with a particular focus on TIC, psychotropic medication review, and caregiver support. MCOs should also closely collaborate with community-based organizations and state agencies to help individuals maintain stable health care benefits and supports as they approach aging out of the system. MCOs should ensure that foster children and their caregivers have access to appropriate crisis services and 24-hour access to case managers or clinicians. Additionally, OHCA should evaluate state plan services in consultation with MCOs, providers, and patient advocates to ensure that therapeutic foster care services, evidence practices such as Trauma-Focused Cognitive Behavioral Therapy, and critical home- and community-based interventions such as Peer Support Specialists and mobile crisis and stabilization services are available to members. OHCA could also encourage a High Fidelity Wraparound model for a subset of children and youth supported by multiple state systems with a SED diagnosis, multiple diagnoses using DSM-5 criteria, or complex trauma.

AI/AN members — have a unique relationship with Medicaid due to the federal trust responsibility to provide for their health care and therefore may need support navigating across tribal-run health systems, Indian Health Services, and the Medicaid program. Oklahoma is home to thirty-nine federally recognized tribes, several of whom run their own health systems or clinics. MCOs should prioritize

building relationships with these tribal systems to understand how best to integrate services for their members. In addition to forming close, collaborative relationships with tribal services and providers, we recommend that MCOs hire tribal liaisons and CHWs as part of the care team to ensure that culturally competent services are provided.

Justice-Involved Individuals — require rapid engagement, and support not only with establishing continuity of care outside of the justice system but also with social supports such as housing and employment. OHCA can consider asking MCOs to play an important part in re-entry initiatives – particularly as part of addressing the opioid epidemic given the high rates of mental health challenges and SUD among the justice-involved population and the extremely high health and mortality risks immediately after incarceration.[10,11] There are a number of approaches that OHCA could consider in partnership with MCOs to improve coordination of care for this population, including facilitating partnerships between MCOs and prisons/jails (directly or through community organizations like Oklahoma's Remerge program) to help effectively enroll individuals into Medicaid prior to their release, or as part of the discharge/reentry process. OHCA can also set criteria that MCOs must follow to enroll appropriate individuals into health homes and require certain screenings and baseline requirements for establishing appointments. OHCA could require MCOs to develop a member-centered Individualized Justice Plan to help individuals successfully transition back to the community, with participation from any community resources relevant to the member's success. Regardless of whether OHCA institutes such a requirement, MCOs should address key social determinants of health for this population such as ensuring stable housing and access to transportation to appointments, as well as support with employment opportunities, which can be a challenge for those with a criminal record. Louisiana's partnership between the Department of Health and Department of Corrections can serve as a good example of this approach: they developed an automated enrollment process that allowed the agencies to share information about individuals set for release in the next nine months, and get them enrolled in Medicaid and linked to a health plan prerelease. Information is shared with MCOs, who can develop care plans as a component of discharge planning.[12]

Individuals with Severe Mental Illness — often have complex physical health comorbidities and complex social needs such as housing instability. As discussed in previous parts of this response, OHCA should engage with MCOs on how to build upon the SMI/SED Behavioral Health Home (BHH) model, and consider requiring MCOs to contract with BHHs and to design value based incentives. BHHs are important to removing barriers to data sharing in order to facilitate better health outcomes, and could look to partner with MCOs to include services such as peer supports, assertive community treatment, and permanent supportive housing, which have shown promise in improving outcomes for individuals with SMI.[13] MCOs could also partner with BHHs or community organizations to establish wraparound models for individuals with SMI in order to prevent homelessness, unnecessary hospitalizations, and other adverse outcomes while helping promote community integration and recovery. These partnerships can include dedicated multidisciplinary support, 24/7 access to a care manager, real-time crisis support, and discharge planning in addition to wraparound services such as transportation, supportive housing, medication management, and individual and group therapy.

[10] https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/
[11] https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf
[12] https://ldh.la.gov/index.cfm/newsroom/detail/4170
[13] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- **Answer member questions timely** via telephone or email and resolve grievances and appeals timely
- **Frequently update provider directories** online to help members locate health care providers
- **Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

1 **What metrics should be used to measure MCO performance with regards to member services?**

We encourage a four-part approach to monitoring the quality of member services, including call centers as well as care coordination and case management.

1. **Measures to Assess Member Experience** — to determine if services delivered by MCOs are improving health outcomes across its members.
   a. As mentioned in our response to **Quality and Accountability Q2**, CAHPS surveys NPS are important indicators of overall member satisfaction as well as contact center performance. MCOs can also implement surveys to measure member satisfaction with care management services.
   b. Particularly immediately following the initial implementation of managed care, Grievances and Appeals data can be an important indicator of member experience and MCO member services. We suggest that OHCA establish a process to closely monitor this data in the initial years following the managed care transition to identify emerging patterns.
2. **Measures to Assess Population Health Outcomes** — to determine if the set of care coordination and case management services delivered by MCOs are improving health outcomes across the population. Examples of related metrics include potentially preventable inpatient and ER admissions and readmissions, total cost of care, member satisfaction, and quality measures and outcomes (e.g., HEDIS and CAHPS scores, metrics from the CMS Child Core Set, and measures recommended by AHRQ).
3. **Measures to Assess Individual Care Management/Care Coordination Outcomes** — to determine if interventions are improving individual member health and well-being. Measures may include rates of medication adherence, care gap closure, ER visits, inpatient admissions and readmissions, and measures of condition management, such as blood pressure control and HbA1c levels.
4. **Process Measures** — to monitor care coordination implementation. Measures could include the number of people eligible for a service but who were unable to be contacted, lost to follow up, or successfully engaged; the number of care plans created; the number of successful contacts made; accessibility measures; ability to accommodate language and cultural competency needs; and caseloads/staffing ratios. In addition, regular audits of care plans should be conducted to ensure all authorized services are provided as expected. Metrics to measure call center performance include first contact resolution, abandoned all rate, and average speed of answer.

Every measure should have a clearly defined source, such as surveys, program-collected data, or claims. In addition, all measures and reports should have a set timeframe during which they are monitored that align with the program or services they are evaluating. As additional populations transition into managed care, MCOs and OHCA will need to reevaluate their approach to monitoring member services and develop more targeted measures specific to populations such as ABD.

2 **How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?**

Effective communication is central to an MCO's ability to serve members and forge the relationships needed to create simple, personalized healthcare experiences. At Humana, our commitment to respect the varied experiences of our associates and members provides us with insight to directly inform the tactics and resources recommended support effective communication approaches.

Linguistically Accessible Material and Interpretation Services — MCOs must develop materials that are available in alternative formats (e.g., braille, large print format), and can be delivered verbally, electronically, through a certified linguistic interpreter, and through an Accessible Screen Reader PDF. Materials and communications should be developed at no more than a fifth grade reading level in both English and Spanish, as well as in other prevalent languages and formats that members note as their preference. For example, Humana's Spanish Website includes in-language health resources such as the Physician Finder Plus tool, PDFs for download, enrollment materials, a translated library with health education materials, and information on Humana's maternity program. To assist members with disabilities, MCO websites should include videos about services in languages and formats representative of the communities they serve.

In addition, we recommend that MCOs provide a call system with a dedicated member language services line as well with an interactive voice recognition (IVR) feature that enables members to select the language of their choice. As part of the former feature, we recommend that MCOs provide access to translation or interpretation services. Humana's member services, for example, include more than 200 languages and American Sign Language (ASL) interpreters, available in person or via video, along with auxiliary aids such as TTY/TDD and handset amplifiers for members who are deaf or hard of hearing.

Strategies with Providers and CHWs — In order to serve subpopulations with low literacy or non-English speaking members, MCOs should forge partnerships with providers suited to serve those areas. We recommend MCOs develop written policies to support minority provider recruitment and retention with the specific purpose of meeting diverse needs statewide. For example, Humana develops statewide Adequacy and Access Plans to detail efforts to assess member language, cultural, physical, and intellectual needs, and develop the interventions necessary to resolve any gaps.

MCOs can also employ CHWs to build trusting and enduring relationships with members, providers, and community-based organizations in person, to facilitate access to services and resources (especially related to SDOH), and to support health promotion and cultural fluency. They can serve not just as cultural liaisons but as a key part of the workforce in, for example, high-volume provider practices where they can help members navigate the broader health ecosystem. Participating MCOs could also consider providing funding to high volume provider practice locations to employ and embed CHWs for their Medicaid members. While CHWs act as a valuable means of building relationships with the community, MCOs should not view them as front line translators and should instead apply their skillsets primarily for the activities described above.

Provider Directories — MCO provider directories should identify any non-English languages spoken by network providers.

Training and Performance Measurements — Healthcare providers are often members' most trusted sources of health education and information. As a result, it is important for MCOs to equip providers with the tools they need to effectively care for members despite linguistic barriers or knowledge gaps that may exist. Cultural education for healthcare professionals is an important component of improving the quality of care delivered to diverse patient populations and can help in addressing racial and ethnic disparities in healthcare. MCOs' provider support models should include training for providers and their staff in an easily accessible format available at times convenient for them. We also recommend that OHCA and MCOs partner with leading organizations to give providers access to trainings on cultural fluency, ACEs, and TIC. Notably, MCOs can also emphasize health equity and cultural fluency, breaking down implicit bias through robust training and education. As such, cultural fluency should be an integral component of organizational culture for each MCO along with a company-wide focus on inclusivity in order to inform initiatives and outreach.

We have also found that measuring and monitoring care is an effective means to understanding when there is an issue and knowing when to address health literacy or provide culturally fluent care. MCOs should use both public and proprietary data to identify disparities within their members' care and work directly with community members to develop and track best practices to address linguistic and knowledge-related gaps.

3 How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

Technology provides a powerful tool, which MCOs can use to engage members, communicate care, and deliver services. MCOs can use technology to build healthier communities by (1) providing digital platforms, (2) harnessing social media, and (3) expanding the ecosystem of services that members can access in their preferred setting. The prevalence of COVID-19 has further amplified and increased the adoption and impact of technology in recent times, with CMS releasing new guidelines to encourage the use of digital tools and telehealth among Medicaid members.[14] While MCOs can offer many powerful technology solutions, the choice of tools should be aligned with OHCA's both immediate and long-term goals and, most importantly, the experience that these tools create for Oklahoma's members and providers.

Establish Digital Platforms — Even prior to the current pandemic, research shows that a majority of adult Medicaid members incorporated smartphone use and digital tools into some aspect of their care.[15] As a result, MCOs can build upon this foundation to both increase access to care and educate members on available wellness initiatives. For example, MCOs can provide the means for members to set up and attend telehealth appointments with their provider from their phone or track daily consumption or calories. Humana, for example, has developed proprietary personalized Medicaid-specific wellness and rewards program and application that incorporate practices of behavioral economics to encourage members to complete healthy activities.

[14] https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

[15] https://www2.deloitte.com/us/en/insights/industry/public-sector/mobile-health-care-app-features-for-patients.html

As mentioned in the response to **Benefits Q1**, MCOs can encourage the use and adoption of digital and wearable remote monitoring tools by providing a digital platform to synchronize with such tools. By doing so, MCOs provide the means for PCPs to better track member needs and provide resources specific for their conditions. MCOs can leverage data, for example, from screening and assessments to create predictive models grounded in SDOH and use them to empower providers to screen and refer patients to appropriate community resources. The previously discussed partnership with OATS to promote senior use of technology also supports technology education and increased access to broadband and mobile devices. Digital platforms have also served as a vital means of continuing care throughout the COVID-19 pandemic by enabling members to keep appointments or learn about topics such as testing availability. Digital tools also enable MCOs to obtain timely and actionable member feedback regarding the effectiveness of the tools themselves as well as their healthcare experience more broadly.

Harness Social Media — As discussed in our response to **Managed Care Enrollees Q3**, MCOs can use social media as a powerful platform to engage members and this is especially true during the current COVID-19 pandemic. Social media campaigns enable MCOs to capture member attention for emerging public health priorities, such as COVID-19, or long-term, priority population health areas such as maternal health. To broaden the reach of these campaigns, MCOs could partner together and with state or national entities for targeted campaigns. For example, Humana utilized Twitter and Facebook to amplify CDC guidance for navigating the COVID-19 pandemic and answer frequently asked questions in a timely manner. Social media is also a strong platform to connect members through support groups to share lived experiences and provide resources and a community for members.

Expand the Care Ecosystem — MCOs can use technology to broaden the range of services members receive by connecting health and social services and expanding the setting in which they receive care via telehealth, virtual care, or digitally enabled transportation solutions that members can access from a phone or mobile device. When members require care but cannot or prefer not to leave their home, MCOs should offer telehealth and virtual care solutions in alignment with state policy and regulations that can bring PCPs, specialists, therapists, care mangers, and other members of their care team virtually into their home. Some tools allow more on demand access to the members care team, which can enable more personal ownership from the member and provide services at time, that are most convenient. For members who want to leave their home but face transportation barriers, MCOs can offer digitally enabled transportation solutions such as Lyft or Uber.

4 **How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?**

Members may lack access to technology and reliable internet connectivity due to financial or geographic circumstances and MCOs must develop strategies to meet members where they are. Utilizing traditional mail to connect with members is still an effective means of communication. However, we know there are many barriers with this option as well. As such, MCOs must develop strategic partnerships with community organizations to more effectively communicate with and engage members in the absence of technological means to do so.

In-Person Outreach and Community Partnerships — MCOs can provide in-person outreach and educational activities and efforts through CHWs, community partnerships, and providing a presence at community events. We believe that MCOs can bridge communication gaps by developing educational materials to share with these partners and conducting direct trainings on health topics and to help them better serve and engage members. In Oklahoma, health departments and the Turning Point Council

work within communities to advance better health outcomes: we recommend that MCOs consider partnerships with organizations such as these and consult them on the best avenues to reach members within their community. MCOs should also consider partnerships with or the deployment of associates to disseminate educational materials at community events and to interact with members at gathering places such as local schools, homeless shelters, BH agencies and addiction recovery centers, food banks and soup kitchens, immigrant and refugee partners, faith-based organizations, and other community events and conferences.

Provider Partnerships — Provider partnerships and associated events are an effective and interactive means to engage members that otherwise would be hard to reach. Since providers are the primary and most trusted point of care for many members, MCOs should equip providers with educational materials and participate in both collaborative events and direct outreach to members from their office. In our markets, we work with providers to host community events and education sessions during which we invite members to call to schedule appointments and get preventive care. For members experiencing homelessness, MCOs could deploy outreach services through their BH provider network to proactively connect to this population in order to locate them, share information, and connect them to resources.

Direct Mail — In addition to the provision of a welcome kit or member handbook via mail, MCOs should use direct mail and flyers to equip members with the basic information concerning their care and/or timely reminders about annual services. Individuals experiencing homelessness often are some of the hardest to reach populations because even options like receiving mail are frequently unavailable to them. Partnering with organizations like the Oklahoma Homeless Alliance, which have mail services for homeless individuals, can support outreach to these vulnerable members. The Homeless Alliance's WestTown homeless resource center is another example of an organization MCOs can consider partnering with to engage with individuals in person.

Reduce Barriers to Technology Access — Humana recommends that MCOs take the following steps to mitigate the very cause of barriers to technology use and communication:

- Partner directly with internet providers in both rural areas and tribal lands to provide expanded low-cost coverage and digital literacy programs.
- Identify opportunities to partner with private and public entities such as the Oklahoma Broadband Initiative, which is working to increase high-speed internet access across the state, or community organizations that could service as hotspots in key areas where members can go for internet connectivity.

To support these actions, we suggest that OHCA provide guidance for MCOs encouraging the use of federal programs such as the Lifeline program, which provides free or discounted phones for various low-income populations (albeit with data usage limits). OHCA can encourage MCOs to invest in value-added benefits such the removal of the data limits for their members. These actions, along with the community partnerships described earlier, are an effective means to increase communication with members who otherwise lack the means to interact via mobile phone, computer, or internet.

5 How can MCOs communicate with members and receive regular input and feedback on program improvements?

Humana strongly supports the patient-centered work that OHCA initiated with the establishment of the SoonerCare Member Advisory Task Force (MATF). OHCA could consider adding the following approaches to existing efforts to gather member input and feedback: (1) the establishment of additional communication mediums (via digital and in-person forums), (2) performance data collection, and (3)

community-based outreach. MCOs can also utilize existing forums, like OHCA's regular tribal consultations, to check the efficacy of communication strategies and adjust where necessary.

In addition to the digital communication, technological tools, and feedback mechanisms described earlier, Humana understands that Member Advisory forums and direct two-way communication channels are a vital means of increasing member satisfaction, and in turn, improving health outcomes. We encourage OHCA to maintain two-way communication by convening diverse stakeholders such as MCOs, healthcare administrators, providers, and consumer/patient groups to provide feedback on program improvements and have a means of giving input for further continuous improvements. Engagement with institutions of higher education, via innovation challenges or strategic planning sessions, are another means of soliciting constructive feedback and identifying further improvements. MCOs can also use data from the annual CAHPS surveys and Patient Experience IVR surveys to look for feedback specific to program features and act as a valuable means to further refine programmatic offerings. In addition, pulse surveys and member interviews act as a vehicle for qualitative feedback and to source new ideas for program improvements.

6 What tools and resources would help members search for providers? What information should be provided?

We believe it is vital for OHCA to encourage transparency of provider performance to empower consumer choice among members. To that end, we recommend that OHCA include public provider profiles via a centralized directory, giving members the opportunity to understand differences in provider networks during their MCO selection process, and later to choose in-network providers based on high-quality performance, information displayed on certifications, and information indicating which providers are trained in cultural competency or trauma-informed care.

Additionally, OHCA could put in place measures to ensure continued accuracy of its provider directory. In 2018, a CMS report noted that 52% of physician listings in Medicare Advantage directories had at least one inaccuracy.[16] Our experience shows that Medicaid directories face many of the same accuracy challenges. Inaccurate provider directories are frustrating for members, but they also add to providers' administrative burden. Inaccurate directories lead to providers referring patients to providers who are not participating with the patients' MCO or giving patients inaccurate operational information such as contact or location information.

There are several innovative projects that aim to address issues related to accuracy. For example, five organizations, including Humana, began a Blockchain pilot in 2018 to improve provider directory information. In the pilot, the five participant organizations use a shared database to manage provider information, enabling updates to directory information to be automatically shared across all health plan participants.[17] OHCA could consider utilizing or encouraging the use of these types of collaborative tools and technology.

Machine learning is another opportunity for improvement in provider directories. While some policymakers have recommended requiring machine-readable provider directories, which is one option to consider, we suggest OHCA examine other types of predictive modeling and analytics to improve accuracy. For example, Humana has invested heavily in improving our provider directories, utilizing a

16 https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf

17 https://www.beckershospitalreview.com/payer-issues/humana-targets-accuracy-of-provider-directories.html

predictive algorithm that uses external data sources to determine the probability of a record's accuracy/inaccuracy. If a record is more likely to be inaccurate, it is tagged for telephonic follow up, allowing for efficient use of resources to update and maintain the directories. Our efforts have shown encouraging results, significantly increasing the accuracy of Humana's Medicare directory.

Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

Questions for Stakeholder Input: Provider Payments and Services

2 **Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?**

To maintain network adequacy for Medicaid members, we suggest that OHCA require MCOs to maintain a minimum level of reimbursement, particularly for primary care. However, we also strongly support OCHA's vision that MCOs can be a source of innovation in advancing value in the Medicaid programs by incentivizing high-quality care. We suggest that OHCA set baseline FFS rates in a forum that allows for participation of providers and MCOs in order to agree on minimum rates that ensure providers stay financially viable, while providing enough flexibility for MCOs to be able to innovate through VBP. As discussed later this response, MCOs can be an important partner to help providers take on more accountability for health outcomes. Through this approach, the state can continue to support its primary care infrastructure while providers in medical home models and other increasing risk-based arrangements can be rewarded for high-quality performance.

4 **What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?**

We suggest standardized communications tools, credentialing functions, and dispute resolution to minimize provider abrasion.

Standardized Forms and Tools for Communications — We recommend OHCA work with MCOs and providers to develop and implement standard multi-payer tools and forms for claims management, prior authorization, and related communications. Retaining a single set of forms, rather than requiring separate forms and processes for each MCO, could help to alleviate one of the most significant set of pain points in a transition from FFS to managed care. Additionally, OHCA could explore the adoption of single sign-on technology to streamline access to MCO provider portals.

Standardized Credentialing — We recommend OHCA centralize provider credentialing and recredentialing, as variations in credentialing processes are a frequent source of frustration for providers. MCOs and providers should continue to advise the development of the centralized credentialing process. We also encourage OHCA, MCOs, and providers to consider the potential for the Credentials Verification Organization (CVO) to serve ultimately across all lines of business and include Medicare and Commercial requirements. Doing so would reduce redundant efforts for providers contracted with multiple types of insurance plans and would help achieve cost reductions for both providers and MCOs.

We have identified the following recommendations:

National Credentialing Standards — OHCA should consider the interplay between national certification vendors and the credentialing process. For instance, if a hospital gains NCQA certification and is also required to undergo the state-level credentialing process separately, this would create administrative challenges and duplication of work. We suggest OHCA allow nationally recognized certifications, such as NCQA, to satisfy state-level credentialing requirements. This accommodation could be even more streamlined if OHCA establishes a direct integration between the national licensure agency and the provider's state Medicaid file.

Provider Education — It will be incumbent on MCOs and OHCA to help educate and assist providers with the new credentialing process. We recommend a multi-pronged approach to assist providers through a new centralized credentialing process. This assistance would include personalized education from MCOs during provider recruitment; updates to the MCO provider manuals and provider websites; and training of MCO call center staff to help address provider concerns and questions. All MCOs need to work closely with providers throughout implementation of the new credentialing system to mitigate potential problems at the outset.

Standardized Provider and Member Dispute Resolution Process — We believe there are multiple options for standardizing a provider dispute resolution process and that valuable lessons can be gleaned from other Medicaid programs. Though provider-dispute resolution process requirements vary, we suggest the following elements be standardized across MCOs:

- The types of disputes subject to the resolution process should be standardized. For example, we suggest claims (e.g., appeals) and nonclaims related disputes be submitted through the process to allow for accurate and complete tracking of disputes
- Forms or templates providers use for submission should be standardized so providers submit the same information regardless of the MCO involved to ensure data transparency
- All disputes, regardless of topic, should be logged and tracked to resolution so OHCA is able to review timeliness of resolution
- Timeframes for resolution should be standardized. In our experience, the most common timeframe for resolution is 30 days, with extensions of 14 days when necessary
- Reporting templates and measure definitions summarizing MCO performance data should be developed so OHCA is able to perform comparative analysis more easily and identify issues by provider type
- OHCA could consider mirroring the requirements for member grievances and appeals set forth in 42 Code of Federal Regulations §438.400 et seq., so these disputes are resolved using consistent procedures and timeframes with which many Medicaid providers are already familiar

Many states' systems establish an external independent review process for providers. While we support this type of review, we recommend OHCA require that providers exhaust the MCO's internal provider-

dispute resolution process prior to accessing an external appeal. In our experience, the vast majority of disputes can be resolved by MCOs internally and without the expense and time delays that are often associated with external appeals.

One unintended consequence of standardization that OHCA should seek to avoid is restricting MCOs' ability to quickly address systemic or operational issues that are identified through the process. While standardization helps to alleviate providers' administrative burden, we recommend OHCA's provider dispute resolution process also have enough flexibility to permit MCOs to respond to provider pain points and improve processes that benefit network providers. For example, Humana has provider relations associates dedicated to proactively identifying sources of abrasion and addressing them, either through changes in processes or procedures or through educational outreach. This team conducts this analysis for individual providers, as well as across provider types, sizes, geographic regions, and other categories. This type of proactive analysis helps us meet our providers where they are to improve their experience and keep their resources focused on care delivery.

6	**How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?**

MCO approaches to help providers navigate plan administrative requirements and reduce provider abrasion should focus on making it easier to provide high-quality care for members while using resources efficiently and effectively. Following are some best practices based on our experience for OHCA's consideration:

Simplifying Prior Authorization — Providers frequently complain that administrative requirements, particularly those related to prior authorizations, create unnecessary burdens on them and their staff. MCOs can establish programs to waive prior authorization requirements for high-performing providers who have consistently exceeded prior authorization performance and quality criteria. Through reviewing a provider's quality HEDIS and utilization (percent of authorizations approved), MCOs can identify providers who deliver high-value care, close care gaps, and refer members for appropriate services and follows-ups. When high-performing providers meet specific targets for certain measures, they could then bypass the standard outpatient prior authorization process for specific specialty care and procedures. This type of program can establish mutual quality and access goals while reducing the administrative burden on providers. OHCA can also look to MCOs to collaborate through multi-payer portals that incorporate interactive claims management and prior authorization solutions. Humana has successfully done this in some markets to increase communication between providers and payers and transparency within the claims process. These portals can give providers ability to self-serve, to check claim status, see whether a particular claim will pass edits, resolve overpayment, initiate an appeal, send attachments to a claim, and message the health plan(s).

We also suggest that OHCA look to MCOs to hire, or have consulting arrangements with a psychiatrist or other provider specialized in SUD, to support ongoing peer-to-peer training and support for BH providers through utilization review. These trainings may include webinars and other group learning opportunities for the provider community to better understand the utilization management (UM) process and understand when and how to how to apply American Society of Addiction Medicine (ASAM) criteria properly through the prior authorization process.

Solving Administrative Claims Denial — Uniformity of payment rules and opportunities for claims testing can alleviate the burden of navigating complex claim processes and avoid denials on nonclinical

grounds. MCOs can help providers solve for this though claims editing tools. For example, Humana's provider portal (described in more detail below) includes a claims editing function so providers can test their claims prior to submission thus avoiding rejection for administrative reasons. We also suggest that MCOs, OHCA, and providers collaborate to identify the most common administrative reasons for claim denials and develop solutions and educational materials to minimize the occurrence of these types of claim denials and identify and resolve other challenges tied to provider claims. OHCA could also consider asking MCOs to pilot their claims processing with a select group of providers (large and small) to identify issues with claims processing before implementing it statewide.

Collaboration across MCOs — MCOs can have a significant impact on reducing provider burden when they work together to identify the issues most burdensome to providers and devise common solutions that can be used by all participants. For example, MCOs can collaborate to identify common types of claims that are rejected due to operational/administrative reasons and work together to standardize the claims submission process and provider education materials. OHCA could also encourage or convene collaboration between MCOs and providers to determine how to collectively simplify the prior authorization process. In order to facilitate collaboration, we recommend establishing a regularly occurring MCO Operational Workgroup. This workgroup could provide a space wherein MCOs can meet with each other quarterly (or more often as necessary), as well as with provider associations, to identify provider burden issues and create solutions that can be implemented in a unified and uniform manner across the state.

Improving Provider Access to Actionable and Timely Information — MCO provider portals create a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative, and clinical transactions. Humana's provider portal contains functionality such as:

- Clinical data management to support provider participation in quality programs and simplify the process to close gaps in care (pre-populated forms with provider and member information so only missing info needs to be provided)
- Secure data sharing, including care plans; medical records; admission, discharge, and transfer (ADT) data
- Provider performance tracking and utilization tracking
- Proprietary Population Insights Compass (Compass) platform

MCO portals can also be accessible from a centralized portal via single sign-on. This can support a provider's normal process flow of checking member eligibility, claims, prior authorizations, and the ability to sign in to the MCO portal with little effort to access specific MCO information for VBP and care plans.

Clear Line of Communication — When challenges arise, whether a claim issue or question about MCO policies, providers need to have a clear line of communication to the MCO. Our experience shows that having a designated point of contact assigned to a provider is critical to providing this line of communication. Humana uses local Providers Relations teams that are dispersed throughout the state to support provider education, communication, and issue remediation. A Humana Provider Relations representative serves as the single point of contact for a provider across all product lines, simplifying the communication and resolution process for providers. This creates much needed and much desired consistency and accountability in helping providers resolve concerns. This representative regularly visits their assigned providers to answer questions and provide or arrange staff training and education, including one-on-one training. If the provider is engaged in value-based arrangements with Humana, the relations representative provides actionable data reports to support the provider's success in VBP.

7 **What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?**

OHCA should look for MCOs that can engage and support providers at all stages of the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) framework. Through regular interactions with providers, MCOs should serve as a partner to providers, collaborating on care for Medicaid members, availing resources, and helping to solve any barriers/challenges. As providers transition into managed care accountability, and particularly when a practice considers entering into a contract with significant risk, we recommend that MCOs conduct a thorough assessment in partnership with the practice to determine its readiness to succeed in the arrangement. These readiness assessments should focus on categories such as infrastructure, clinical operations, and financial operations to uncover areas where the practice can use additional support and position the providers for success.

We believe that MCOs can help providers prepare for and succeed in shared accountability models in a few key areas:

- **Provider Supports** — Provider Relations teams are often the most direct contact point with providers to help them advance their capabilities for VBP, improve quality, and troubleshoot any challenges. As practices are being asked to take on increasingly complex models, Provider Relations Representatives must be increasingly cross functional. Humana's Provider Relations Representatives have team members who specialize in billing and coding, clinical quality, care management, and practice transformation.
- **Plan Operations** — Timely claims payments and providing access to timely data are critical to provider success in VBP models. Humana has invested significantly in population health management reporting capabilities to help providers close gaps and improve quality, as well as interoperability with EHRs to share clinical data with providers.
- **Care Coordination** — Most VBP models have implicit or explicit requirements that providers deliver care coordination or care management services. Plans and providers have an opportunity to collaborate to optimize the deployment of payer and practice-based care management and care coordination roles and activities to improve patient experience and engagement in their health.

To align incentives between MCOs and providers, OHCA could establish statewide targets for VBP penetration at each level of the HCP-LAN APM framework and/or by provider type (e.g., primary care, BH, hospitals). Some states have set thresholds for the percent of providers who must be engaged in VBP arrangements, and increase those percentages as well as institute additional thresholds specific to HCP-LAN APM levels three and four and provider type, each subsequent year of the managed care contract. Establishing targets across the HCP-LAN framework allows providers to begin in upside-only rewards programs, then after demonstrating success, advance to upside-only shared savings and potentially moving into downside-risk bearing arrangements after demonstrating the necessary capabilities. As an example, North Carolina DHHS established a five-year VBP strategy for the Medicaid program as part of their current transition to managed care. This strategy built from existing VBP efforts used within FFS Medicaid and other payers and gave broad flexibilities for MCOs and providers to innovate while still establishing targets based on the HCP-LAN framework.[18]

As mentioned in our response to **Quality and Accountability Q3**, we also suggest that OHCA consider requiring MCOs to align their provider and/or member incentive programs with prioritized HEDIS

[18] https://files.nc.gov/ncdhhs/VBP_Strategy_Final_20200108.pdf

measures and clinical goals. This approach would help OHCA influence the direction of plans' VBP programs to align with their prioritized quality improvement and population health goals. Similarly, OHCA could consider adding structural measures that align with and incentivize its delivery system transformation goals, such as provider EHR adoption, connection to HIEs, and provider participation in the OHCA PCMH model and/or VBP models more broadly.

8 **How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?**

There are several ways that we suggest OHCA look to MCOs to partner with PCPs. As part of any MCO's population health management strategy, we recommend, based upon our experience, the following best practices:

Data Integration into EHRs — While data can be shared with providers in many ways, we have found that direct integration to the EHR makes it easier for providers to take this information into account as part of their regular workflows. For example, Humana and Epic are advancing interoperability that will give providers integrated and real-time access to patients' medical history, health insights, and treatment options, which, in turn, improves quality, increases member satisfaction, and enables cost efficiencies.

To support PCPs and advance innovation in primary care, MCOs can organize provider support programs around the following key capabilities:

- Team-based care and practice-led care coordination
- SDOH integration
- BH integration
- Practice transformation
- Telehealth and technology
- Quality improvement

Actionable, Timely Quality and Population Heath Data — Providers should have an easy way to proactively understand their performance against quality metrics and receive risk stratification data inclusive of services from other providers in order to effectively manage patient care. We offer a proprietary population health management solution that gives provider practices timely, actionable data on quality, utilization, and gaps in care, with customizable user-friendly reports to help them manage their patient panels.

Insights into Factors Impacting Care —Many of the factors that impact health and wellness are based on SDOH and dynamics in members' communities; as providers work with their patients, insights into these issues can help them create a tailored treatment plan that proactively addresses barriers members may face to adherence. MCOs can provide tools that assist providers in identifying and understanding these needs, and make available specialized staff with deep knowledge of SDOH as described in our response to **Benefits Q3**.

We also suggest as a best practice that MCOs have dedicated staff to work hand-in-hand with provider practices to improve quality outcomes and assist in practice transformation efforts to improve their population health management capabilities. At Humana, our advisors meet with PCPs to identify pain points, support them with additional data needs and in the integration of BH and physical health, and address SDOH needs. We also hire CHWs or work with practice or community CHWs who liaise among Humana Care Managers, providers, and CBOs to coordinate referrals for members to community-based services and programs and to foster integrated efforts among all parties. CHWs also facilitate engagement between members and their PCP and encourage the completion of health promotion activities.

MCOs can also support provider training in the ways described below. Given provider time constraints, OHCA could also look to MCOs to take a coordinated approach.

- **Person-Centered Care** — The provision of a person-centered experience requires cultural fluency, including an understanding of implicit bias, trauma-informed care, and ACEs. Cultural fluency is especially important in addressing critical areas of health disparities, such as maternal-child health outcomes. MCOs can partner with leading organizations to bring these trainings to providers in an easily accessible format at times convenient for them. One approach to monitoring providers' participation is to allow them to enroll through the provider portal; for online and virtual trainings, where completion is tracked automatically. For in-person trainings, the MCO or training partner can track attendance in the system.
- **Administrative Support** — To minimize administrative burden and to help PCPs accept increasing risk, MCOs can support with improving coding accuracy and helping providers stay up to date with clinical criteria such as ASAM to facilitate effective claims processing. For example, Humana developed the Coding and Documentation Education and Training (CADET) Program in which educators collaborate directly with provider practices to establish best practices in coding.
- **Mentoring and Coaching** — While telemedicine is not the universal solution to the current barriers that PCPs face in the provision of care, it is a powerful tool for offering providers opportunities for peer-to-peer learning (e.g., Project ECHO) and case consults. As we will discuss in more detail in the response to **Network Adequacy Q4**, we also recommend that MCOs collectively develop a strategic partnership with leading universities to support interdisciplinary collaboration and support.

We further recommend that OHCA provide incentives and supports that allow practices to make strategic investments to overcome barriers to VBP success and promote practice transformation. Our provider partners may request our Practice Transformation Incentive. Our Practice Innovation Advisors collaborate with providers receiving this incentive to maximize its potential reach. Providers can use the Practice Transformation Incentive to build new data capabilities and operating efficiencies. (For more information about the Practice Transformation Incentive, please refer to our response to **Care Management and Coordination Q3**.*)*

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

Examples of industry standards include:

- Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
- Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
- Require all Primary Care Providers have at least some same-day acute care appointments
- Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)

Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

3	**How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?**

To attract provider participation in Medicaid, it is essential that MCOs have a track record of properly and promptly compensating providers in order to incentivize participation up front. OHCA can encourage participation by setting standards and sharing practices to improve processes, facilitate faster payment times, and lower claim error or denial rates. When testing any new payment system, we suggest that OHCA add a focus on the development and testing of systems and processes that result in prompt and accurate payment. These systems and processes should be designed to differentiate process flows based on provider type, the volume of claims received, and the method by which those claims are submitted. Smaller providers, often serving rural or underserved areas, face even more difficulties. By accounting for variations in existing capabilities and methods, the development of the front-end editing components of this complex payment system will increase the likelihood that MCOs approve the vast majority of claims during the first pass. We recognize that lack of alignment in metrics used for VBP is often a challenge for providers, and also suggest that OHCA, MCOs, and providers work together to establish a set of metrics for the Medicaid program that align across MCOs and other payers to minimize burden. MCOs should also look to their other lines of business to bring in providers they already work with to accept their Medicaid members. For example, Humana has the largest MA service area footprint in Oklahoma and is the only statewide MA plan. As we do in other markets, we will work to incorporate our current providers into our Medicaid network.

Another key to recruiting and retaining providers is a provider relations model that recognizes and incorporates the unique needs of each community and provider through flexible approaches tailored to their needs (please refer to our responses to questions in the **Provider Payments and Services** section for specific proposals and details about Humana's provider relations model). MCOs can also assist providers in creating workplace wellness initiatives and programs to support providers and their staff in managing the stress and emotional challenges they often experience, particularly with respect to the provision of TIC services. Provider burnout has negative impacts not only on MCOs' provider partners but also on the quality of care they are able to provide to members. MCOs should design processes that reduce provider frustration and make it easy for providers to participate in the Medicaid program and access help.

Humana also recommends that MCOs maximize resources by collaborating with other contracted plans to address shared goals. In states such as Kentucky and Florida, we have had success collaborating with other MCOs to address a range of operational issues, such as reporting requirements, education initiatives, and changes to program integrity trainings, along with initiatives focused on education and outreach. Through collaborations with other MCOs, we believe there are opportunities to improve access through innovative solutions such as development of residency or other training programs in partnership with a university or FQHCs. We also believe that collaborations across MCOs around outreach and education would benefit residents particularly in rural and tribal areas, and in the ability to increase access to BH resources. For example, MCOs could partner with public schools to provide targeted education around bullying, online/cyber risks, suicide prevention, and other behavioral topics.

4	**How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?**

Humana believes that MCOs can and should take an active role in addressing workforce development for different types of providers. In our experience, MCOs have the infrastructure and resources,

including highly skilled trainers, to partner with providers to develop and implement training and education programs that attract more individuals to specialized professions and promote staff retention. Moreover, MCOs frequently have partnerships in place with universities, local agencies, and community colleges to address other workforce development issues that can be leveraged to develop the overall medical workforce, including increasing the number of applicants and new graduates pursuing positions in portions of the profession facing shortages. With a large number of rural and provider shortage areas across Oklahoma's 77 counties, we strongly support MCO collaboration to promote workforce development, and offer OHCA the following recommendations based on our experience in other states:

Statewide Workforce Council — OHCA should engage MCOs to participate in the Governor's Council for Workforce and Economic Development Health Workforce Subcommittee run by the Employment Security Commission and Department of Health as a part of Oklahoma Works. In this forum, OHCA, MCOs, Universities, health systems, Community Colleges, Career Techs and other associations and key regional partners can assemble and identify specific statewide healthcare workforce and population health needs in order to build a strategy to address gaps and shortages.

Rural and Tribal Area Rotations — Studies have shown that residents trained in a rural setting tend to go into practice in rural areas.[19] OHCA could work with a group of MCOs to collaboratively fund large-scale initiatives such as the development of clinical rotations, residency programs, and rotating placement of specialists in rural areas, training programs in rural areas for nurses, pharmacists, and other specialty providers, any of which might be an expense too large for a single MCO. Target areas for collaborative investment could be defined in partnership with FQHCs and medical schools, and other stakeholders to set up the necessary infrastructure to facilitate this type of program. Similarly, MCOs should consider ways to collaborate with universities to bolster and/or develop focused recruiting efforts to increase the number of rural and tribal students who attend college to become healthcare professionals.

Workforce Development Networks — These networks, which are formal linkages between schools and potential employers, promote workforce development across multiple types of positions, leveraging both formal and informal sources of information about training and job opportunities. These networks have been used successfully in several states such as New York, Arkansas and Wisconsin, in single communities as well as on a regional level.[20]

Partnerships with Leading Universities — MCOs can work with local partners and with leading universities to create strategic academic partnerships focused on three key areas: community, education, and research. The interdisciplinary collaboration required to meet the complex needs of members and help them thrive in the workforce requires evolved health education and interdisciplinary training. The educational component of our strategic academic partnerships intends to prepare students to practice interdisciplinary, whole-person-based care to support clinical, social, and environmental health cooperatively as they would in the field. Many of these same educational concepts could be offered to practicing health professionals as continuing education in support of community-wide workforce development. OHCA, MCOs, and academic centers can work together to establish a common

[19] https://www.fiercehealthcare.com/practices/20-million-federal-grants-new-residency-programs-will-train-more-doctors-for-rural-areas

[20] https://cybercemetery.unt.edu/archive/allcollections/20090116064310/http://srdc.msstate.edu/publications/srdcpolicy/green.pdf

catalogue of classes and trainings on topics such as patient-centered care, BH integration, and value-based care, which medical schools and clinical training programs can then integrate into their curricula.

Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

1 **How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?**

The regular gathering of qualitative and quantitative member satisfaction data is a key strategy to understanding access-to-care member concerns and identifying opportunities to advance person-centered care delivery. The previously mentioned MATF provides a valuable means of requesting feedback and could be supplemented with proactive measures of MCO performance (from the patient perspective) that do not create a burden for providers. These methods include, but are not limited to, the collection of member satisfaction data through annual surveys, post-visit surveys, and member and provider advisory councils. Humana has found that the voice of the customer surveys following phone interactions provide critical insight into members' views. Member and provider complaints and grievances are an additional way to monitor member satisfaction with providers and MCO services, as well as providers' level of satisfaction with MCO support.

In addition to the tactics described earlier, we also suggest the following approaches:

CAHPS Drill-Down and Simulation Surveys — These supplement the official annual CAHPS survey described earlier by affording additional access to member-level data that can quickly be utilized to inform performance improvement initiatives. These surveys allow the administrator to get a pulse on Medicaid member experiences in targeted geographic areas or among specific provider panels. MCOs and/or OHCA could collaborate before conducting such surveys to determine common objectives, how to utilize the results, and align on key aspects of survey design (e.g., timing, frequency, and scope of questions).

Post-Visit Surveys — Another method is to conduct brief surveys with members after they have a doctor's appointment. This survey could ask about overall satisfaction with the visit, whether they had difficulties scheduling the appointment, if they had to wait a long time before seeing their doctor, etc. These surveys provide quick feedback into challenges members face when scheduling appointments at the provider level, which enable MCOs to identify opportunities to partner with providers and address any access-to-care challenges quickly.

Analysis of Disparities — While measurement of person-centered care delivery is an evolving area (as discussed in the response to **Quality and Accountability Q3**), MCOs can collect and analyze race, ethnicity, and language information to identify disparities across clinical programs and interventions and help pinpoint where care may not be meeting member needs.

Innovative Technology — Another capability that MCOs should consider is the provision of technology solutions to integrate grievance and appeals workflows such as an online chat feature, voice analysis, post-chat, or surveys across member facing plan functions. Additionally, advances in artificial intelligence present opportunities to further analyze member information and their interactions with both call and chat systems themselves as well as the MCO's representatives. Members who are hard of hearing, deaf, or with speech impediments may also find chat functions more convenient and easier to use. In addition, the integration of feedback mechanisms and evaluative tools provides the opportunity to both improve the member experience and reduce the burden on associates.

Access Audits — Conducting provider access audits (secret shopper calls) is one way to get immediate feedback on a provider with minimal burden on the practice. Provider access audits are also useful because MCOs are able to respond quickly, if necessary, to contact the provider and partner together to identify solutions to the barriers limiting availability.

To minimize provider burden even further, MCOs and OHCA may consider a cooperative effort to monitor availability, conducting audits collectively and compiling results, thereby, minimizing duplication and increasing transparency across organizations. Using the results of these surveys to inform Key Performance Indicators and understand whether best practices are being implemented would allow OHCA to work with MCOs to make results actionable.

2 How can the state and MCOs use appeals data to improve utilization management and access?

Humana sees UM as a critical way for MCOs to ensure that the medical needs of members are met while maintaining the sustainability of Medicaid-funded care. However, we recognize that disparate UM programs and practices have the potential to place a burden on providers and frustrate members. Data gleaned from the appeals process provides a way to improve the member experience during the necessary UM process, increase the accuracy of analysis, and use insights to improve the resulting access to services available in community settings.

OHCA may wish to consider the following practices to improve UM and access:

Standardizing the Dispute Resolution Process — As mentioned in the response to **Provider Payments and Services Q4**, the types of disputes subject to the resolution process should be tracked and standardized in the dispute resolution process. As part of standardizing the dispute resolution process, we suggest that OHCA standardize the forms and templates by which members and providers submit grievances and appeals. We also recommend that all disputes, regardless of topic, are logged and tracked to resolution, so OHCA is able to review timeliness of resolution, and that OHCA provides a standard timeframe for resolution. We have found 30 days to be the most common resolution timeframe, with a 14-day extension a suitable option.

Tracking Trends and Improving Utilization Management — We suggest that OHCA establish guidelines and closely monitor denials, grievances, and appeals to track developing trends. Data should be comparable across MCOs and OHCA should regularly engage with MCOs around UM metrics to ensure performance. MCOs should track and monitor appeals data to identify trends such as procedures or services that are routinely being denied, appealed, and subsequently approved. MCOs should have the ability to reassess these services to evaluate their inclusion in the prior authorization list. Identifying such trends can influence the utilization review plan, which outlines the responsibilities and authorities of all utilization review activities, details the procedures for evaluating the medical necessity of admissions, extended stays, and professional services, and provides guidelines for reviews of the

appropriateness of care settings. By leveraging appeal data, the review committee will have better insight into which areas to focus on during the utilization review and can use this information to build the foundation for a strong utilization management strategy that balances cost-effectiveness with timely access to care.

Preventing claims denials and medical necessity reviews relies on good clinical documentation. As such, we recommend OHCA encourage the use of clinical documentation improvement (CDI) specialists. CDI specialists can identify if a provider has failed to document key activities that caused a case manager to flag the service as medically unnecessary. By implementing these measures, OHCA can help MCOs to achieve a higher accuracy rate during the UM process, reduce both member and provider burden, and ultimately increase access for members seeking care.

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- **Gain accreditation** by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- **Maintain an Oklahoma presence**, including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- **Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

Questions for Stakeholder Input: Administrative Requirements

1 **How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data do require?**

Data sharing can be streamlined by reducing the number of interfaces necessary to send and receive pertinent health data. With Oklahoma's interest in moving to a single state HIE demonstrated by their recent RFP, it would be possible to leverage this resource to limit integrations necessary to achieve interoperability. We strongly recommend that the needs of sharing a consolidated patient record among providers and MCOs be considered during the development of the state HIE to support initial data exchange. Our experience shows that states that invest in their HIE infrastructure and convene stakeholders in a meaningful governance structure to build a trusted network are more successful in supporting care coordination.

Data privacy and security can be maintained at rest and in motion by setting minimum encryption criteria, utilizing federally recognized data sharing standards, and setting up sound governance over data and data uses. Oklahoma could consider opportunities for all providers and MCOs to agree to a *Trusted Framework*, abiding by the latest Trusted Exchange Framework and Common Agreement (TEFCA) and convening under the oversight of a board representing the broad interests of the healthcare community. States where we have seen effective models include New York, North Carolina, and Michigan. For example New York provides a useful framework to effectively coordinate data-sharing among multiple HIEs; North Carolina (NC HealthConnex) collects robust data by requiring Medicaid providers and MCOs to submit data to an HIE for value-based care contracts and also works directly with private HIEs to obtain data; and Michigan's HIE (MiHin) positions itself as a conduit to share data to all parties and directs MCOs to incentivize collection of quality data from providers.

OHCA could also consider a single sign-on provider portal or require plans to participate in a portal that is linked with the OHCA provider portal in order to make it easier to share streamlined information across OHCA, MCOs, and providers, and so that providers don't get fragmented information from multiple MCOs that serve their patient population.

2	**What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?**

The presence of disparate sources of personally identifiable information (PII) data collected and stored among a multitude of data warehousing locations creates a barrier to data sharing. There is also an issue of data integrity and quality. Providers need access to accurate and timely data that they trust and know how to effectively use to improve care. Implementing processes to ensure the integrity of data collected from providers — and used to calculate VBP payments — is key as providers take on risk caring for complex populations. To reduce duplication and barriers to data sharing, we encourage partnership among MCOs, OHCA, and provider groups to establish common standards, forms, and transmission modes to facilitate data exchange. Once this partnership has determined the proper content, format, and use of data, we suggest that OHCA consider promulgation of guidelines to both standardize data and provide approved avenues to gain member consent to share data in secure form. While secure data sharing currently may occur through disparate or unwieldly avenues such as a provider portal or individual practice platform, we recommend that MCOs encourage streamlining tactics such as the requirement to use a single sign-on service or the use of the *Trusted Framework* as mentioned previously.

As discussed in our response to **Benefits Q2**, we also suggest use of a comprehensive consent form that accounts for specially protected health information to help facilitate BH data sharing to overcome challenges with sharing protected patient data. MCOs should also develop incentives for providers with limited resources and technology infrastructure to invest in EHRs and stronger internet connectivity. This could be combined with trainings, comprehensive materials, and MCO advisors to ensure that providers can leverage their existing tools for data sharing and are able to transform workflows and data processes in alignment with leading practices.

Finally, adding to the discussion of a *Trusted Framework* above, we recommend set standards for each type of data to enable reliable comparison and interpretation of data between systems. A lack of defined rules, standards, and policies that govern information sharing can be a barrier to the exchange of information between systems. We suggest OHCA form a technical workgroup to collaboratively identify barriers to data sharing, and establish a workable, long-term approach to sharing real-time data between MCOs, providers, and the state in a safe, secure, and timely manner.

IBM Watson Health

August 17, 2020

Oklahoma Health Care Authority (OHCA)
Attention: Mr. Kevin Corbett

RE: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design; Planned Comprehensive Medicaid Managed Care Implementation, #80720200002

Dear Mr. Corbett]:

International Business Machines (IBM) Corporation, Watson Health appreciates the opportunity to provide input related to the upcoming Planned Comprehensive Medicaid Managed Care Implementation Request for Proposals (RFP).

We have provided input related to identifying member and provider fraud, and fraud detection and prevention methods, as described under the Administrative Requirements topic.

If you require any clarifications, please contact me at your convenience:

Rod D. Burnett
IBM Watson Health Account Executive
Telephone: 573.291.4061
E-mail: rod.burnett@us.ibm.com

Sincerely,

ADMINISTRATIVE REQUIREMENTS

How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

MCOs can use proactive methods of data analysis to identify provider fraud. Both prospective and retrospective reviews should be conducted. MCOs should have robust data analytics that help the MCOs identify provider billing that is not in line with State or Federal requirements. Additionally, States and their MCOs are increasingly supplementing oversight with rule-based algorithms that detect policy non-compliance with machine learning techniques to detect aberrant trends or patterns. This type of advanced analytics should be incorporated in the State's requirements.

MCO's data analysis should not be limited to provider fraud -- analysis of member activity is also essential. Using analytical tools MCOs can quickly identify over-utilization by members among other prohibited activities.

MCOs should review and understand Oklahoma's Medicaid agency policy and configure edits and data algorithms that reflect the uniqueness of Oklahoma's program. These State specific edits should be reported to the State and included in the State's Medicaid payment system. In concert with the above activities MCOs should be required to validate and approve encounter data. They should have a rigorous, independent, audit team to ensure data quality and accuracy.

MCOs should be required to report all adverse actions they take against any provider or member. This would include when an MCO terminates a provider for fraud or abuse or any other reason. Likewise the MCO should report any action taken against a member, such as being placed in a member restriction program (lock-in). These adverse actions should be shared with State personnel who register providers and other MCOs to ensure that the provider is reviewed for appropriateness to remain in the Medicaid program or MCO networks. Collaboration among the MCO program integrity teams and the State program integrity team is at the center of IBM Watson Health's managed care oversight implementation support services.

MCOs must do fraud, waste and abuse training so that they can monitor the fiscal integrity of their program. Additionally, more targeted training, particularized to an MCO's employee's job responsibilities, would increase FWA detection.

MCOs should require regular reporting to the State program integrity unit of all allegations of provider or member wrongdoing and the actions the MCO is taking to determine the validity of those allegations. They should report all investigative activities on a provider and may often be required to do a medical review of a sufficient number of random records of a provider to ensure compliance with State and Federal rules. Further the MCOs should be required to provide written documentation of their investigation, such as the medical records, coding review, medical review and data that form the basis for a referral to the State of suspected Fraud or Abuse. At IBM Watson Health we have developed reporting metrics and requirements that meet and exceed federal guidance and requirements.

Regularly scheduled meetings with the MCO and the State are essential. A partnership with the State and open communication is essential for successful operations and can provide a forum during which current data analysis and provider/member current reviews can be discussed in an effort to further eliminate fraud, waste and abuse.

MCOs should have to identify, collect and report overpayments identified, both administratively and non-administratively, to the State. These overpayments should be analyzed to determine if edits, policies or procedures of the State or of the MCO need to be created or amended.

To set a foundation for success, it will be critical for the State to define MCO responsibilities for program integrity very specifically in the contract and to establish formal processes for reporting and acting on suspected fraud, waste and abuse. IBM Watson Health has the experience and expertise in these, as well as other, areas to assist the State in becoming a leader in managed care program integrity and oversight.

Santa Clara University

August 20, 2020

To Whom It May Concern:

Re: 80720200002

I understand that the state of Oklahoma is planning to issue a Request for Proposals (RFP) for Managed Medicaid later this year. I was previously the Director of the U.S. Center for Substance Abuse Treatment, part of the Department of HHS Substance Abuse and Mental Health Services Administration. Now, as a private citizen, I would like to provide public comment for Oklahoma's consideration.

One of the questions the state is asking for feedback on is about Benefits: "How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?"

Certainly, Opioid Use Disorder (OUD) is a current and ongoing epidemic, but in addition to this, Oklahoma must address its dramatic growth rate in stimulant (methamphetamine) overdoses. Oklahoma has the 2nd highest rate of stimulant overdose deaths in the U.S. This rate is nearly as high as Oklahoma's OUD overdose rate: https://stateimpact.npr.org/oklahoma/2018/03/30/oklahoma-ranks-near-the-top-in-overdose-deaths-from-stimulants-cdc-data-show/

Extensive research shows Motivational Incentives (also known as Contingency Management) to be the most robust, evidence-based, and cost-effective treatment for stimulant use disorders – which has no known FDA approved medication treatment. Growing adoption by multiple state and national commercial insurers, as well as state Medicaid agencies and single state substance abuse authorities, attests to the effectiveness and cost-savings of this intervention. This is a badly needed tool for addressing both the opioid and the stimulant epidemic.

The COVID-19 epidemic and the concurrent opioid and stimulant disorder epidemics reveal a bleak outlook for US drug-related mortality. Beyond the ongoing opioid epidemic, the next epidemic is already emerging: stimulant use disorders. From 2012–2018, cocaine overdose deaths have more than tripled and deaths involving stimulants (e.g. methamphetamine) have risen nearly 6-fold.

In the midst of this crisis of overdose deaths from stimulants and the COVID-19 epidemic implementing effective, cost-effective treatment such as motivational incentives (contingency management) in treatment programs is critical.

Please see the attached infographic and Clinical and Cost Effectiveness document.

Thank you for your attention to this issue of vital public health importance.

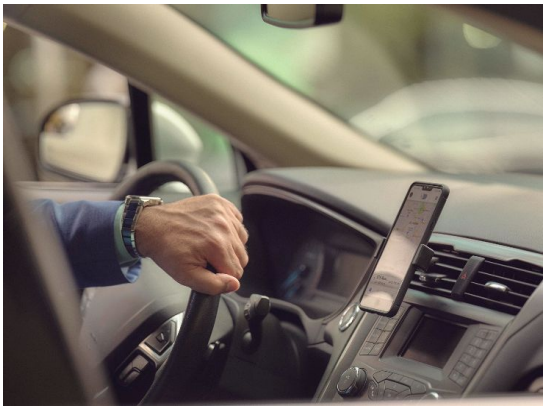
Sincerely,

H. Westley Clark, MD, JD, MPH, DFASAM
Dean's Executive Professor of Public Health
Santa Clara University
Santa Clara, California

Response to Request for Public Feedback

for

SoonerCare Comprehensive Managed Care Program Program Design



Prepared by Lyft, Inc.

for

Oklahoma Health Care Authority

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Executive Summary Letter

August 21, 2020
Oklahoma Health Care Authority
4345 N Lincoln Blvd
Oklahoma City, OK 73105

RE: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

To Whom It May Concern:

Lyft was founded with the mission of reconnecting communities through better transportation. At the heart of that mission are commitments to building partnerships that decouple the right to mobility from auto ownership and expand affordable, accessible and convenient transportation options for those that need it most.

When considering healthcare, one of the key social determinants of health is access — to care, services, and supports that promote health and wellbeing. Transportation is the key to unlocking that access — and Transportation Network Companies (TNCs), commonly known as ridesharing, are a cost-effective, reliable, safe, and convenient transportation option. Lyft is grateful for the opportunity to discuss how rideshare can be one component of SoonerCare's upcoming procurement.

Rideshare can strengthen existing non-emergency transportation (NEMT) provider networks, support overall satisfaction for appropriate Medicaid members, and maintain a cost-effective approach for Medicaid programs. Lyft has a track record of using our national rideshare platform to effectively plug into the existing Medicaid NEMT ecosystem and reinforce credentialed transportation provider networks — relieving stress in their operations, adding flexibility, and improving access for Medicaid members. Rideshare can be an important component in the ecosystem, and is also best positioned to strengthen NEMT networks of transportation managers, with current transportation managers and transportation providers continuing to address a full spectrum of passenger needs in the marketplace.

As SoonerCare prepares to issue the upcoming RFP for qualified managed care organizations (MCOs), Lyft supports the state's goal of introducing TNCs into NEMT to further improve and modernize the program for Oklahomans. We are confident that Lyft can play a collaborative and effective role as a member of the NEMT ecosystem to address costly health risk factors across communities. The following document provides feedback for structuring the upcoming RFP, in particular restructuring to have MCOSs carve-in NEMT, and aims to inform best practices and guidance for how TNCs, such as Lyft, can support the SoonerCare population.

Thank you for reviewing our attached responses and we look forward to having the opportunity to participate in the upcoming RFP. Please reach out to our team if you have any additional clarifying questions.

Respectfully submitted,

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About Lyft

Lyft was founded in 2012 by Logan Green and John Zimmer to improve people's lives with the world's best transportation, and is available to approximately 95 percent of the United States population. Lyft is committed to effecting positive change for our cities by promoting transportation equity through shared rides, bikeshare systems, electric scooters, and public transit partnerships.

Over the past four years, Lyft has forged partnerships with leading companies across the healthcare ecosystem to provide affordable and reliable transportation for patients. Lyft's national scale, network, and focus in healthcare transportation make us an effective partner for qualified Medicaid members eligible for NEMT.

Lyft has deep experience partnering with state Medicaid agencies, including Arizona, Virginia, Tennessee, Georgia, Michigan, Texas and others, helping bolster their NEMT by providing rides for eligible beneficiaries. Leading healthcare organizations and public agencies trust Lyft for a number of reasons:

- 9 of the top 10 non emergency transportation managers partner with Lyft, including brokers that have experience partnering with the state of Oklahoma.
- 9 of the top 10 health systems use Lyft to provide reliable rides for patients.
- The top 5 health plans work with Lyft via transportation managers to provide rides across the care continuum.
- Lyft was the first national rideshare company to enter the healthcare transportation sector.
- Lyft has invested deeply in expanding our work within the Medicaid community, growing a dedicated healthcare team which works alongside experienced business, legal and compliance professionals to expand access to care around the country. Lyft has expertise to collaborate with healthcare policy makers and regulators.
- Lyft has continuously demonstrated our commitment to safety and maintains a dedicated support team.

Response to Request for Public Feedback Areas

Benefits Provided Through MCOs

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

> Screening enrollees for social needs
> Providing enrollees with referrals to social services and tracking the outcomes of referrals
> Partnering with community-based organizations or social service providers
> Requiring employment of community health workers or other non-traditional health workers

The healthcare industry needs a standardized approach to collecting SDOH data to help evaluate the effectiveness, costs, and operational efficiencies of social care interventions. Such a coding system would also allow for more in-depth analysis that evaluates how different types of social care interventions drive results for different populations. For example, we could measure how the health outcomes of a patient change when they have both access to reliable and affordable food and transportation programs.

One initiative making notable strides is the Gravity Project. This collaborative aims to create consensus-driven standards that address social care in clinical settings, integrate SDOH data into digital infrastructure, and develop standards for collecting and exchanging individual-level SDOH data. The Gravity Project has identified three SDOH domains that have the largest impact on health outcomes and utilization[1]:

- Food insecurity
- Housing instability and quality, and
- Transportation access

The efforts of the Gravity Project align with the work we're doing at Lyft to help understand how we can reduce transportation barriers and improve access to care. This summer, Lyft became a sponsor of the Gravity Project, where we will sit on their Strategic Advisory Committee, participate in public Working Groups, and support efforts to test and deploy standard code sets across the healthcare and human services ecosystem. With this work, the industry can identify vulnerable patients who face transportation barriers in receiving care, understand how severe these barriers are, and track how transportation-related policy and programmatic interventions can alleviate these barriers. This will revolutionize the way we deliver care, making it easier for healthcare professionals to track patients's needs, leading to healthier communities and better wellbeing for all.

[1] https://www.hl7.org/gravity/

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

An aspect of MCO procurement which can advance SoonerCare's benefits and access to care for its members is introducing innovations in non-emergency medical transportation (NEMT). Introducing TNCs into Medicaid NEMT can improve and modernize the program for Oklahomans, while increasing flexibility and accessibility for members.

Lyft, as a TNC, provides Medicaid members with the opportunity to receive on-demand rides, potentially eliminating longer wait times and also allowing for quick access to transportation for urgent situations. By including TNCs in their transportation networks, health plans and their transportation partners can more easily accommodate time-sensitive trips for authorized riders. Trips that are often more cost-effective given Lyft's pricing model. Lyft has engaged in pilot demonstrations that reiterate the value that rideshare can bring to Medicaid NEMT, and support increased accessibility in transportation across a state. For example, Lyft has worked with Tennessee's Medicaid agency TennCare, Tennessee Amerigroup, and UnitedHealthcare Community Plan in Tennessee to launch a rideshare Medicaid NEMT pilot with transportation manager Tennessee Carriers Inc., who leveraged Lyft as the sole rideshare provider. Pilot summary reports indicate that the Medicaid NEMT pilot has led to[2]:

- 42% increase in PCP visits
- 99% decrease in grievances
- 50% decrease in gaps in primary care
- 92% of riders rate their trips 5 stars

How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance?

As an NEMT partner, Lyft believes that transportation to and from health care appointments for SoonerCare members is a crucial intervention to address transportation insecurity and provide access to care.

Transportation, however, can also provide access to other non-medical needs. Lyft has worked closely with a range of programs and community partners to address a combination of health-related social needs. Improved access to transportation can directly address many social determinants of health and mitigate risk arising from health related social needs. As Oklahoma considers key aspects of program enablement addressing social risk factor mitigation for MCOs and/or providers, OCHA should encourage interventions across categories which can have multifaceted impact on SDOH.

For example, Lyft created a Grocery Access Program as a part of the Wheels for All initiative, which aims to address several social risk factors:

[2] Amerigroup-Lyft Pilot Observations & Findings Summary - May 2020

Lyft's Grocery Access Program component	**Health related social need**
Access to transportation	Transportation insecurity
Access to fresh food	Food insecurity
Financial assistance	Income insecurity
Social interaction	Social isolation
Physical activity (shopping within the store)	Lack of appropriate space for physical activity

Lyft's Grocery Access Program focuses on where transportation can play a meaningful role to help individuals in need access healthy food. Lyft partnered with 15+ local organizations to provide flat-fare rides to/from grocery stores for people living in food deserts. Partners focused on connecting their communities to healthier and more affordable food options. These organizations include Martha's Table in DC, GrowNYC in New York, Uplift Solutions in Philadelphia, and St. Francis Center in Los Angeles. Participants' average commute time was cut by more than half (from 35 minutes down to 17 minutes) during our six month pilot program in Washington D.C. with Martha's Table. Over the six-month pilot, nearly 500 participants took over 5000 flat-fare rides in DC alone. Furthermore, as stated by one participant: "With the money saved we can now buy more food." Lyft now has the opportunity for further evaluation with program data, survey data, and MCO partners providing claims data to understand if the Food Access program also had an impact on food or transportation insecurity status, and health related or cost outcomes.

Along with our grocery access programs, we also support programs that provide transportation for employment. Since March 2019, Dakota County, in Minnesota, has partnered with Lyft to provide on-demand transportation to individuals who qualify for the Medicaid Home and Community-Based Services Waiver Program. Residents who qualify for the program can utilize Lyft for transportation to and from their employment, and for other social needs.

Additionally, Lyft has partnered with several leading national and local organizations dedicated to workforce development in order to deliver free or discounted rides to people making their way through the employment pipeline. We are focused on communities that stand to benefit most from short-term transportation support, and our nonprofit partners play a vital role of connecting individuals in need with Lyft rides in 35+ markets across the U.S. and Canada. Lyft's Jobs Access Program focuses on three key moments in the employment pipeline that are critical to individual success, and where transportation can play a major role:

- Rides to/from job training programs
- Rides to/from job interviews
- Rides to/from the first three weeks of employment, until individuals receive their first

paycheck and begin to pay for their own transportation

Lastly, Lyft has also partnered with UniteUs, a technology company that builds coordinated care networks to connect health and social care providers to provide ride-enabled referrals through the UniteUs platform. By integrating Lyft's ridesharing services with UniteUs' coordinated care network, thousands of people across the country will have improved access to health and social care services. Coordinators and service providers who use UniteUs to make electronic social care referrals can order or schedule a Lyft ride on-demand to help patients access the care they need to live healthier lives. This national partnership will help meet the increasing demand for health and social care services in communities across the country.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Lyft encourages OCHA to allow TNCs to be a mode of transportation for MCOs and partners to utilize for Medicaid NEMT rides. Lyft operates in State Medicaid programs across the country. In fact, 14 states and Washington, DC have incorporated and launched TNCs into NEMT programs. Under these programs, TNC rides are making an impact in reducing patient no-show rates by 27% and can reduce costs for healthcare organizations by up to 32%[3].

MCOs partner with Lyft, or with transportation managers, to utilize Lyft's booking and ride dispatching tool, "Concierge," in order to schedule patient transportation. Using Lyft Concierge's integration into their transportation management platforms, partners can immediately send patients a ride, schedule one for later, or let patients request a ride within a 24-hour window. Lyft Concierge enables partners to schedule rides on behalf of patients — with no Lyft app or smartphone needed from riders. Lyft has had strong success in partnering with transportation managers nationally. Success stories include a partner utilizing Lyft to dispatch "rush" rides for members. By utilizing Lyft, our partner was able to reduce their transportation costs, reduce their grievance rates and reduce their patient wait times from 60 to 8 minutes. Additionally, Lyft has introduced new features, like Flexible Ride, which enables members to have more flexibility as to when they initiate their rides. This helps in limiting no shows and late cancellations. Riders are sent an SMS link in advance of their scheduled pick up time, and can utilize the link to control when they get picked up (based on a set pickup time frame), saving partners time in having to book scheduled and/or return trips. Flexible rides can be sent on-demand or scheduled in advance, so partners can set up transportation exactly when members need it. Flexible rides are especially easy for members who need round-trip transportation. Riders will have a link that lets them easily request a return ride when they're ready. When members are in control, pickups go more smoothly, leading to fewer rider no-shows and cancellations.

[3] Lyft Concierge Rating Pilot, May 2019

Quality and Accountability

Areas for quality measurement include population health goals identified as state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes

What measures of health outcomes should be tracked?

NEMT metrics should be included within MCO performance measurement to ensure a holistic picture of member's health, access to care, quality of care, and member experience. Including:

- **Improving member's health:** Increased PCP visits
- **Access to care:** Reduction in missed appointments
- **Quality of care:** Reduction in unnecessary ED utilization
- **Member experience:** High member satisfaction, low reported member grievances

These metrics have been used as effective evaluation tools by Lyft's stakeholders when engaging in NEMT pilots and programs. For example, in Tennessee we tracked the number of minutes it takes for the transportation provider to arrive. On average, it takes 9 minutes and 42 seconds from the moment a Lyft ride is ordered to the time the driver arrives at the destination. By contrast, it took 30 minutes for a conventional provider. Cutting this wait time by two-thirds proved an improvement in both the member experience and physician office experience (where the member would have been waiting). Even more importantly, this time difference showed the value and difference between a member making or missing their appointment.

Care Management and Coordination

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

There is strong evidence that NEMT as a component of Medicaid programs decreases unnecessary medical costs while ensuring access to care for crucial member populations. NEMT has been shown to be cost saving for patients with asthma, congestive heart failure, diabetes, and pregnant women receiving prenatal care. Based on a 2005 review by the National Academies of Sciences, NEMT has been shown to be cost effective for preventive and primary care including influenza vaccinations, breast cancer screening, colorectal screening, and dental care. NEMT has also been shown to be cost effective for patients with mental health conditions, ESRD, COPD, and hypertension. NEMT services benefited Medicaid patients with chronic conditions regardless of whether the beneficiaries were living in rural or urban areas. Therefore, NEMT is a strong intervention for supporting population health and reducing the per capita cost of care, when used within relevant populations.

A retrospective analysis of claims conducted by Avalere for Lyft cited that the top two drivers for NEMT rides for Medicaid members across five different states included CKD (Chronic Kidney Disease) and opioid related disorders. Additionally, there is a high utilization of NEMT services among patients with mental health conditions and those with substance abuse disorders, as well as intellectual disabilities.

To get the value of NEMT for health outcomes and cost, SoonerCare needs a strong network which Lyft can support and provide. By including rideshare in NEMT networks, Lyft can further reinforce and elevate the value of NEMT by supporting reductions in ER visits and appointment cancellations while also supporting care plan adherence and appointment adherence. One of the main reasons Lyft is added to NEMT networks for Medicaid members is the flexibility that Lyft provides, which allows for increased transportation access to members with chronic conditions.

Member Services

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

The TNC model overall is an innovation, and makes NEMT more effective and efficient. By providing an on-demand network for maximum flexibility, technology-enabled dispatch to the nearest driver, and 2M drivers across the country; large supply yields more competitive pricing, improved customer experience, better on time performance. Below are some of the innovations to NEMT that Lyft can provide:

- *GPS:* One of the many ways that Lyft can help states combat Fraud, Waste, and Abuse for NEMT rides is that each ride is tracked via GPS, allowing the department certainty that traditional NEMT doesn't provide that any given ride is to/from an approved location, as applicable.
- *Automated voice calls:* Neither the Lyft app nor a smartphone is required by riders. Lyft will detect if the member's number is a landline and automatically call the rider with all of the ride details.
- *Two-way rating system:* Lyft takes rider and driver feedback seriously. Our two-way rating system lets riders and drivers rate each other anonymously after every ride, and our Trust and Safety team reviews all concerning feedback. We will take appropriate action — including potential deactivation from the platform — should any driver or rider be found in violation of our Community Guidelines.
- *Venue mapping:* If a large hospital campus or building with different Department entrances is a destination, Lyft can specify custom pickup and dropoff locations to make it easier for riders to find their Lyft rides.
- *Flexible rides:* Flexible rides give riders more control when they want to request their rides, resulting in seamless pickups. With flexible rides, a ride link can be sent to a passenger for a certain day, and riders can request the ride whenever they are ready.

The primary product that is used by MCOs for Medicaid NEMT is Lyft Concierge. Lyft Concierge is a desktop solution that enables our partners to seamlessly request a ride on behalf of their

patients from one central portal, even if they don't have the Lyft app or a smartphone, with alerts through texts and calls to landlines. Concierge makes it easy to access more reliable and affordable transportation while providing increased visibility and transparency, with real-time ride tracking and 24-hour customer support. The Lyft Concierge API (Refer to Appendix A for further details) allows organizations to build seamless transportation experiences into their own applications. Flexible rides from Lyft Concierge enable organizations to schedule and cover the cost of a ride that passengers can request for themselves.

How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

Lyft Concierge enables MCOs, and partners, to schedule rides on behalf of members— with no Lyft app or smartphone needed from riders. Lyft Concierge sends patients ride details through SMS, including the driver details, ride map, and arrival times. For the population of riders that may not own a smartphone, Lyft can detect if a number is a landline and automatically call the rider with all of the ride details, such as the driver's name, the make of the car, and the estimated ETA. If the rider misses the call, they can call back 1-800-836-LYFT to hear their ride details.

Provider Payment and Services

Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud

Lyft is committed to working with the state to become authorized transportation providers in order to effectively plug into the existing NEMT ecosystem for SoonerCare and reinforce transportation provider networks. In order for Lyft to bring its value, efficiency, and proven track record to Oklahoma's Medicaid program and recipients, OHCA should align NEMT requirements for TNCs with the Oklahoma statewide TNC law, which provides oversight for transportation network companies, and already requires motor vehicle checks, and state/federal criminal and sex offender background checks for all drivers.[4] In other words, Lyft is fully authorized and regulated based on the Oklahoma TNC state law--and this governing authority can be used for NEMT as well. This has been the approach in other states to leverage TNCs in NEMT.

Lyft Provider Requirements

1. Lyft must comply with the Oklahoma statewide TNC law when performing non-emergency medical transportation (NEMT) services, Lyft will not be subject to traditional NEMT requirements
2. Background Checks
    a. Lyft must comply with the Motor Vehicle Record Checks and criminal background checks for drivers required under the Oklahoma statewide TNC law.
    b. Lyft must conduct healthcare exclusion screening for TNC drivers.
3. Vehicle Requirements

[4] Oklahoma Transportation Network Company Services Act, §47-1019.

    a. Lyft must comply with the vehicle requirements under the Oklahoma statewide TNC law
4. State Requested Audits
    a. Lyft will work with partners when a state regulator conducts audits according to its agreement with partners.
5. Insurance
    a. Lyft must comply with the insurance requirements under the Oklahoma statewide TNC law.

A key part of integrating TNCs as a provider for NEMT rides is defining the population that will be considered appropriate to use NEMT TNC rideshares. Below are the **TNC-specific appropriateness considerations:**

- **Medicaid Recipient Appropriateness for TNCs** - ***partner (MCO or transportation manager/broker) responsibility to triage the individual*:**
    - Appropriate:
        - Recipients who are cognitively and physically appropriate for Lyft services -
    - Not appropriate:
        - Members who fall into select categories of Mental/Behavioral Health cohorts
        - Minors (18 and under) riding by themselves should not use rideshare
        - Members needing assistance with multiple car seats.

In other states, Lyft and industry stakeholders have been included in effective processes for stakeholder comment when TNCs are being incorporated into the NEMT program. We would recommend a similar approach.

Network Adequacy

How should MCOs work with providers to ensure timely access to care standards are met?

Based on our Medicaid NEMT work in states we are currently operational in, and work conducted with our MCO partners, Lyft has consistently shown that rideshare can drive additional cost and operational efficiencies within the NEMT ecosystem. Lyft has shown to reduce no-shows by up to 27%. Additionally, wait times when utilizing Lyft are approximately only 3 to 10 minutes. Health plan members who have access to Lyft as an NEMT provider have been shown to prefer Lyft; 4 out of 5 patients prefer a Lyft to traditional transportation options (Lyft Concierge Rating Pilot, May 2019). Results from a study with USC Keck School of Medicine/AARP/UHC show that when participating seniors were provided with unlimited access to Lyft for three months, they self-reported a 90 percent increase in quality of life.

Just as every Medicaid member may not need NEMT, not every NEMT eligible member is appropriate for a rideshare. However, by allowing existing transportation providers to focus on patients with higher levels of needs, rideshare acts as a reinforcement to the existing transportation network and ecosystem. Therefore, rideshare is not only a driver of improved

patient experience for those members who are appropriate for rideshare, but also supports a stronger transportation experience for those who are not appropriate for rideshare.

Grievances and Appeals

How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

We take our privacy obligations very seriously. All healthcare support-related issues are handled exclusively by a dedicated team focused on support for our healthcare organizations and their patients. Our Trust & Safety team is available 24/7 via the Critical Response Line when members need to report safety issues. Additionally, to give SoonerCare members immediate access to emergency help in case they ever need it (and to help them ride a little easier even when they don't), we built a 911 button into the Concierge ride map. It's there for both riders and drivers, and when riders tap it, we will display the vehicle info and current location so they can quickly share details with emergency dispatchers. To resolve issues, Lyft works in lock-step with our partners to resolve challenges.

Lyft continuously strived to provide a top tier service in order to limit and prevent any member grievances; we are also committed to quickly and adequately resolving any feedback or concerns. Lyft, additionally, has continued to prove our ability to prevent member grievances. Based on a Lyft Medicaid NEMT pilot with Virginia, Lyft maintained a <1% grievance rate for transportation. Our Medicaid NEMT pilot in Tennessee also showed a 99% reduction in grievances.

Recently, Lyft published data from some of our recent partnerships with MCOs, where we were able to demonstrate positive feedback based on our partnership. In 2018, Centene worked with its transportation managers to launch Lyft pilot programs at four subsidiary health plans: Buckeye Health Plan (Ohio), Sunshine Health Plan (Florida), Peach State Health Plan (Georgia) and Superior Health Plan (Texas). The goal was to understand how rideshare can improve the member experience. Results to-date include:

- 66% decrease in member-rider complaints
- 99% on-time arrival rate
- 85% of rides receive 5/5 stars
- 1/5 star ratings dropped from 10% to 1%
- Average wait time decreased from 28 minutes for a traditional NEMT ride to just seven minutes for a Lyft

Administrative Requirements

How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

Lyft signs Business Associate Agreements (BAAs) with our partners as required by HIPAA, and therefore limits our uses and disclosure of "Protected Health Information" or "PHI" according to the terms in the BAA. Lyft typically receives very limited PHI from its contracted healthcare partners in order to allow transportation services to be requested through our platform. For example, Lyft ride requests contain a rider's Name, Telephone Number (if available), and pick-up and drop-off location addresses. Lyft trains its workforce on HIPAA annually and has implemented role-based PHI access limitations in its systems. For those team members with PHI access, each query is logged and attributed to a specific individual.

Additionally, workforce members are required to sign confidentiality and responsible use agreements that bar them from accessing, using, or disclosing customer data outside the confines of their job responsibilities.

How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

Lyft is committed to reducing and preventing Fraud, Waste and Abuse on all levels. We train employees who support the healthcare business on HIPAA and on Healthcare Fraud, Waste and Abuse as required by state healthcare programs and commercial insurance payers.

Additionally, Lyft is committed to price transparency and strengthening guardrails that can prevent fraud:

- Commitment #1: Full pricing transparency
    - In Lyft Concierge, SoonerCare NEMT partners will see upfront prices when rides are requested in most cities. What a partner sees is what is paid, as long as the date and destination don't change, no stops are added to the ride, and time and distance are in line with the estimate.
        - When one of those factors comes into play, the ride distance may change. At that point, Commitment #2 kicks in, and Lyft automatically reviews the ride for any issues. Lyft's upfront prices are calculated dynamically according to a variety of factors including, but not limited to, fees, taxes, tolls, time of day, and promotions. At times of day when demand for rides is higher than the number of available drivers, our prices will be higher than at other times. When partners confirm a pre-scheduled ride, the price that is shown is locked in at the time of the request in most instances. The price shown when a ride is pre-scheduled may be different than the price seen for the same ride requested on the day it takes place.

- Commitment #2: Leading-edge fraud alert programs
    - Best-in-class machine learning technology automatically detects patterns suggesting FWA and proactively reviews and eliminates its causes. Our alert systems spring into action when they detect the following data patterns:
        - Excess distance
        - Excess duration
        - Excess time in destination geofence
        - Drop-off different from destination
    - Our program reviews rides where the final time and distance are materially different from the estimated time and distance. When we detect FWA, we will notify the NEMT partner, review the cause of the issue, and use all reasonable efforts to credit invalid costs back. If a NEMT partner is subject to third-party audits, Lyft is happy to cooperate in providing information reasonably necessary to enable completion of audits audits and comply with related obligations.
- Commitment #3: Control over pickup and drop-off locations
    - To help make sure riders get where they need to go, Lyft provides guardrails around destination changes within Lyft Concierge. Lyft drivers cannot use their Lyft app to change the pickup or drop-off locations that are confirmed in Concierge before the ride occurs. This policy is designed to ensure rider safety and full pricing transparency.

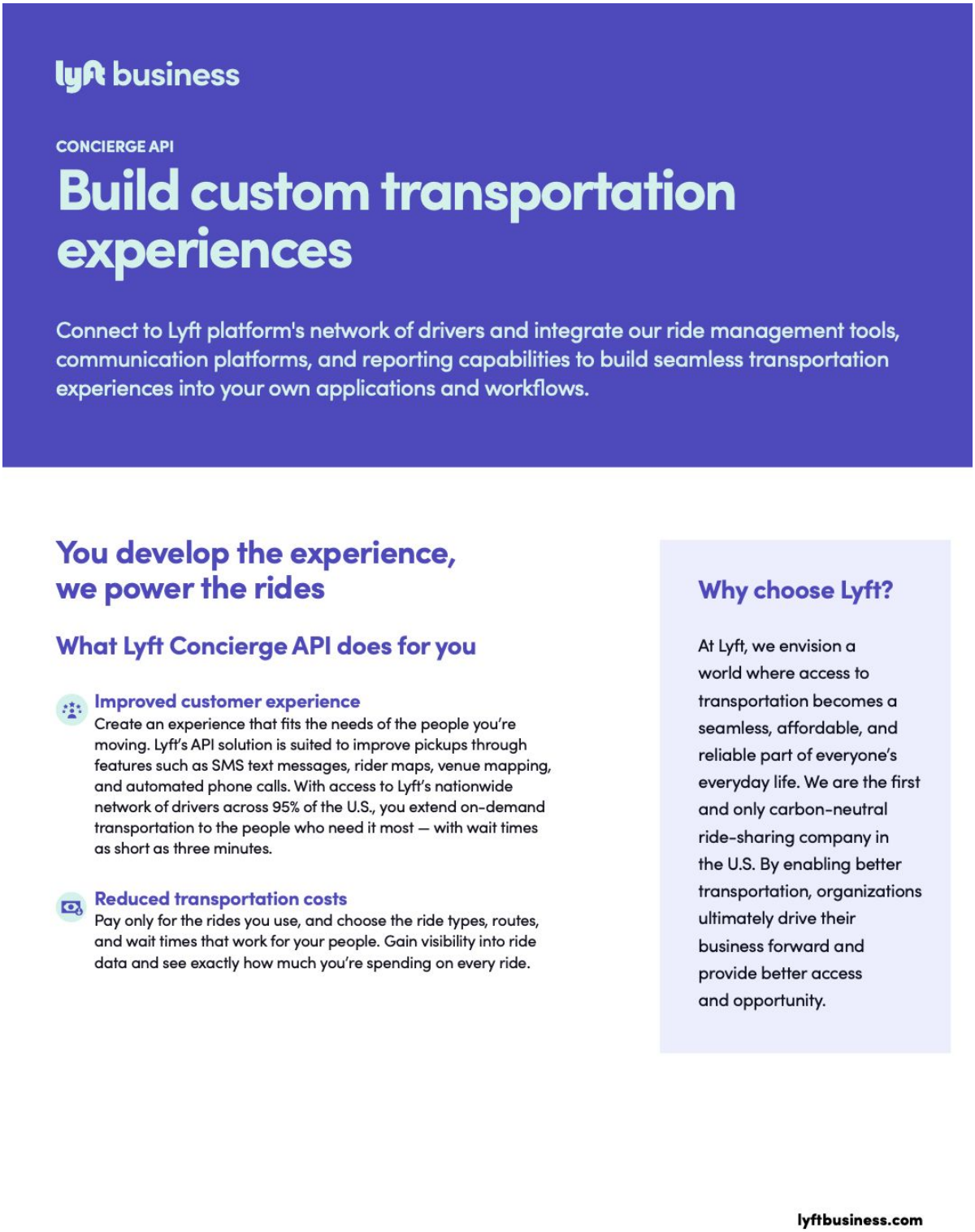
Conclusion

As OCHA prepares for the upcoming MCO procurement for SoonerCare, Lyft appreciates OCHA's acknowledgement of rideshare and the critical role rideshare plays in an NEMT network. We encourage OCHA to ensure rideshare is incorporated as an option for MCOs into the NEMT program to bring reliable, on-demand, high quality service to members. We believe Lyft can play a collaborative role with partners in all corners of health care and across communities to address costly health risk factors if we can operate as a member of the NEMT ecosystem.

Thank you for the opportunity to comment on the Request for Public Feedback to support the next MCO procurement.

Appendix

A. **Lyft Concierge API One Pager**



lyft business

CONCIERGE API

Build custom transportation experiences

Connect to Lyft platform's network of drivers and integrate our ride management tools, communication platforms, and reporting capabilities to build seamless transportation experiences into your own applications and workflows.

You develop the experience, we power the rides

What Lyft Concierge API does for you

Improved customer experience
Create an experience that fits the needs of the people you're moving. Lyft's API solution is suited to improve pickups through features such as SMS text messages, rider maps, venue mapping, and automated phone calls. With access to Lyft's nationwide network of drivers across 95% of the U.S., you extend on-demand transportation to the people who need it most — with wait times as short as three minutes.

Reduced transportation costs
Pay only for the rides you use, and choose the ride types, routes, and wait times that work for your people. Gain visibility into ride data and see exactly how much you're spending on every ride.

Why choose Lyft?

At Lyft, we envision a world where access to transportation becomes a seamless, affordable, and reliable part of everyone's everyday life. We are the first and only carbon-neutral ride-sharing company in the U.S. By enabling better transportation, organizations ultimately drive their business forward and provide better access and opportunity.

lyftbusiness.com

Improved operational efficiency

Customize your integration so that it fits into your existing workflows — no need to retrain your team on a new set of tools.

Reduce the frequency with which you need to call riders and drivers. Riders get all their ride details with SMS or automated phone calls, and you can send notes directly to drivers.

Schedule rides up to seven days in advance — we'll notify the rider once their ride is on the way.

A dedicated team

Industry expertise: Since 2016, we've been building API integrations with partners across a variety of use cases and industries — healthcare brokers, healthcare EHR systems, auto software systems, travel industry, and more.

Integration that fits into your existing workflows: Our dedicated engineering team will work with you to plan your development resources and seamlessly integrate Lyft into your operational workflows.

Customized launch plan: Lyft works with you to customize your testing and launch plan to ensure success.

Continued support post-launch: A dedicated team will support you on technical issues, and continue to work with you on implementing new Concierge API features.

Get your questions answered: Our Lyft Business Support Center is a resource for frequently asked questions. Submit an issue associated with lost and found items, login, billing, and ride cost disputes, and you'll get a response within one business day.

Lyft is committed to safety

Lyft has a Trust & Safety team dedicated to reviewing allegations of incidents and accidents as well as a "special resolutions" team in place to monitor these issues and coordinate responses with our API clients as needed. Safety incidents and accidents reported through our Lyft Business Special Resolutions contact form will be directed to both of these teams to ensure a quick response.

MEDICAID MANAGED CARE FOR THE AGED, BLIND, AND DISABLED

LeadingAge Oklahoma represents not-for-profit providers of aging services across the continuum of care, representing nursing homes, assisted living, adult day services, PACE, home health, case management, hospice, and senior living communities. We look forward to being an engaged partner to study opportunities to advance long term care programs for the Aged, Blind, and Disabled. In order to achieve the goal of providing access to quality care, for less cost, it is imperative that any program focus on long term success through wellness initiatives instead of short-term savings. There should be incentives for quality outcomes, achieved through person-centered service care management models that focus on wellness initiatives to maintain health or avoid future declines. Savings must come through improved health outcomes, not merely cutting costs. Programs must include provider responsibility, accountability and member satisfaction.

Current Programs

There is concern with the increasing costs associated with the current Medicaid program. Provider rates have not kept up with the ever-escalating costs of care. Quality providers are struggling to continue to maintain the enhanced staffing needed to adequately care for the increased acuity of the nursing home population. Over 20,000 Oklahomans receive ADvantage waiver services, with many moving to a nursing home at the final stage of life, at a much higher care level, with increased costs of care. Any new program must address the acuity of the nursing home population if increased home and community-based services are utilized. By expanding home and community-based options such as adult day services, more elderly Oklahomans can remain in their home in a care partnership with family members and caregivers.

Our Legislature struggles to understand the growing number of individuals in the Medicaid program. In the less than 15 years, the number of individuals 65+ is projected to increase by more than 40%. However, no provision has been made to address improvements to reduce spending or funding for sustainability of current programs and services. While the amount being spent is concerning to some leaders, more concerning is the fact that Oklahoma is ranked 49th in the quality of long term care services. Oklahoma has some outstanding providers, yet too many providers still fall short of the quality of care that is expected.

We must work toward a more seamless system of long term care that offers options for service delivery that consumers need, in a setting they want, in a market where they have a choice of providers. The goal should be to build a long term care system that delivers better care and utilizes healthcare dollars more wisely by looking at wellness models to make our communities healthier and work toward more integration of cost-effective home and community-based services. The system should include greater provider accountability and ethical standards.

- **Any new program must include:**
  - Improvement of the beneficiary experience.
  - Focus on improvements in health outcomes as a way to reduce costs.
  - Rates that encourage the delivery of high quality services in home and community-based settings and support the goal of community integration.
  - Contracts that provide performance-based incentives tied to outcome measures
  - Penalties for poor health outcomes-based performance or non-compliance.
  - Protections afforded by the ADA and Olmstead serving beneficiaries in the most integrated settings.
  - Enrollment/disenrollment services provided at no cost to the beneficiary.
  - Choice counseling and education on additional opportunities for disenrollment.
  - Provide a third party consumer protection service to help beneficiaries understand their rights, responsibilities, and how to handle a dispute with the managed care plan or state.
  - Individualized service planning and delivery.
  - Encouragement of active participation by the beneficiary, family members and others chosen by the person or designee in all decision making that impacts the beneficiary.
  - Integrated physical health and behavioral health.
  - Comprehensive person-centered service planning and oversight of care across all available settings.
  - Member is actively involved in care planning meetings and actively participates directly in their plan of care.
  - MCOs must provide all services, for all members, throughout the state.

- **Program Development:**
  - Must have representation by all stakeholders including members, their families, population advocates, state agency involved with current services, with input in advisory capacity from organizations representing senior care services.
  - Consideration must be given to geographic challenges. Develop time and distance standards for service delivery.
  - Savings must be derived through effective care coordination and efficient use of resources to, at a minimum, maintain members' health outcomes, with a focus to improve members' health outcomes. If short term cost savings are the focus, we will never achieve the goal of improving the quality of care and quality of life for the members, or long term cost savings for the state.
  - Program must focus on wellness in order to achieve long term savings through any type of care coordination model.
  - There must be priority for fully integrated care models that address wellness initiatives.
  - Services must be person-centered, with member choice in services and settings with a single
  - Focus to improve health outcomes in the least restrictive, cost effective setting.

- **Program Development: (continued)**
  - Program should have a pilot stage of implementation before statewide rollout.
  - Town Hall forums must be conducted in regions throughout the state in order to collect stakeholder input.
  - All individuals must meet eligibility standards for Medicaid with substantial fines imposed on individuals for any transfer of assets or sheltering of assets to qualify for the program.
  - Medicaid approval must be granted only for qualified individuals and any fraud in incorrect financial reporting must be investigated.
  - Member choice and involvement must be included in the care planning process.
  - Current PACE models and other managed care pilots/demonstrations must be exempted from any program, independent from any coordinated care program.
  - Administrative and managerial procedures that prevent, monitor, identify, and respond to suspected provider fraud must be implemented.

Considerations for New Program Development

- **Finance:**
  - Disclosure of implementation costs.
  - Disclosure of administrative costs.
  - Disclosure of service costs.
  - Details of how the program will produce cost savings while maintaining or improving current programs/services.
  - Actuarially sound financial projections.
  - Require a medical loss ratio of not less than 88% of what a care provider spends on member care services compared to the total revenue received in payments. Failure to meet this standard would result in penalties, with the amount below the minimum being returned to the state, and continued noncompliance resulting from removal from the program.
  - Provider payments based on objective quality benchmarks in service delivery and health outcomes with incentive payments for member quality of life improvement and satisfaction results, and fines with penalties imposed when member outcomes fall below acceptable standards or experience adverse outcomes. Minimum payments set at current provider rates.
  - Withholding of payments for non-reporting of beneficiary data.
  - Annual review of program finances and quality outcomes to make a yearly determination for the continuation of the program including number of members served, average cost, length of stay, number of transitions from HCBS to nursing homes, and other relevant data.

- **Monitoring of the Program:**
  - Assemble an Advisory Board that reports to the Legislature monthly the first two years of implementation and then quarterly thereafter on the program, the savings, the sources of the savings, member satisfaction, health outcomes, clinical care, quality of life, access to services, and the overall status of the program. The Board would be made up of members, or their families, senior advocates, representatives from the disabled and blind populations, social workers, case managers, along with others involved in programs/services that serve the ABD. This will provide a means to continually assess the success of the program and ensure that all interested parties have a venue to communicate any program concerns.
  - Produce a yearly program report with details of plan savings, provider changes, and any changes to the program or future plans for the program.
  - Contingency plan for any type of provider interruption or natural disaster.
  - Monitor and report decreases in services/usage of providers. Provide a monthly report to the Advisory Board for the first two years, then quarterly, thereafter, with a copy to the OHCA.
  - Formalized process to address quality issues, lack of services, services during appeals, means of disenrollment that offers consistent services through the transition, proper notification and response time for change in plans or benefits.
  - Member Satisfaction survey conducted semi-annually for 3 years and then yearly thereafter. Report Results of Member satisfaction Survey to aforementioned Advisory Board and OHCA.
  - Require the development of a Care Coordination Ombudsman program with statewide representation by field ombudsmen that would visit members, service providers and families to monitor member satisfaction and service delivery.
  - Formalize a complaint process with outlined steps for resolution and appeal. Must define fines for service interruption, poor care, or failure to meet the program's outlined quality standards
  - Develop a process to assess the managed care program annually, and assess any potential need to discontinue the managed care program.
- **Quality Standards:**
  - Services to be all-inclusive to assist members in service accessibility. Single point of entry for coordination of all services. Any supplemental services not included will be coordinated through a care coordinator to avoid gaps in service delivery.
  - Once the service plan has been developed, it would be signed by the member or the members' representative to ensure coordination and support of the family or members' representative, updated yearly or upon change in condition or a change in a provider.
  - Member choice in program with a streamlined process to change service providers.
  - Upon demonstration of improved or sustained quality of life and quality of care outcomes, providers would be eligible to receive financial incentives. These would be tied to the outcomes and defined programming relating to all of the dimensions of wellness, reduction in falls, hospitalizations, rehospitalizations, reduced emergency room visits, and improvement/ stabilization of health conditions.
  - Quality care must be maintained, realizing that some areas of services are not capable of generating savings.
  - Protocols to address the prevention and reporting of abuse, neglect, and exploitation of any program member.

- **Quality Standards: (continued)**
  - Quality of Care External Quality Review – Implement all voluntary protocols:
    - Validation of encounter data reported
    - Validation of consumer or provider surveys of quality of care
    - Calculation of performance measures
    - Conduct performance improvement projects

- **Program Components:**
  - Use of hours as the unit of service for noninstitutionalized services, with electronic monitoring of visits.
  - Identify the service area for all members to ensure provider access within a reasonable proximity to their home, with no more than 50 miles in rural areas.
  - All care providers and those in contact with members must complete a National Fingerprinting Background Check.
  - Interdisciplinary team approach to care management involving the member, direct care staff, and other identified participants in the members care coordination program.
  - Must include an audit provision to monitor any fraud or abuse in the program, with outlined penalties and payment recoupment provisions.
  - Identified criteria and process for program disenrollment that provides a seamless transition for the member to access alternate services.
  - Program must include a toll free 24/7/365 hotline for members.
  - Must offer a choice of service options and settings for members.
  - Program must include a comprehensive assessment to determine the appropriate service model for the member and the development of a care plan which will be the basis for the quality metrics for the program, with the care plan being updated with any change in the member's condition or a change in provider.
  - Website for the program to report finances and publicly reported quality metrics for all providers, including the Eight Protocols for the External Quality Review Organization's function:
    - Assessment of Compliance with Medicaid Coordinated Care Regulations
    - Validation of Performance Measures reported by MCOs
    - Validation of the implementation of Performance Improvement Projects
    - Validation of the Encounter Data reported by the MCOs
    - Validation of the Implementation of Enrollee Surveys
    - Calculation of any Voluntary Measures
    - Implementation of any Performance Improvement Projects
    - Conducting Focused Studies on the status of the Quality of Health Care
  - Include a Resident's Right provision:
    - Control over one's life
    - Right to participate in decisions about one's services and treatment
    - Right to appeal a verdict of a grievance
  - Website to include the MCO or other providers, their strengths and weaknesses with respect to quality, timeliness and access to health care services furnished to members.

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SoonerCare Comprehensive Managed Care Program

Managed Care Enrollees

- **How and when should OHCA transition ABD and other initially excluded individuals to managed care?**
  MCOs by their very nature incur operating expenses *and profit* above current program costs. With resources for the ABD population already extremely limited, needed health care infrastructure and provider rates will be adversely affected. It is recommended that the ABD population be excluded from consideration for privatized managed care at the present time. The state should allow a minimum of three years' experience with MCO managed care in other programs before considering the feasibility of expansion to the ABD population. After such time, a pilot program within the ABD population should be implemented, and evaluated, prior any MCO managed care transition. Any transition for ABD should allow at least one year for stakeholder and member education.
- **Should the state require each MCO enroll all populations?**
  Successful programs such as PACE that are all-inclusive and have demonstrated success should *not* be included.
- **How can MCOs better engage individuals in their health care and healthy behaviors?**
  The key to any managed care program is improving health to enhance health outcomes, thereby reducing costs. This would involve required health care communications, healthcare visits, and lifestyle changes for the members.

Stakeholder Input: Benefits

- **What would make it easier for individuals to access care?**
  Communications options for members to advance telehealth, transportation to healthcare visits, and a 24/7 help line to facilitate member and healthcare provider communications.
- **What strategies would improve the integration of services?**
  A critical piece would be case managers who would fully understand and are able to communicate the full scope of service options to meet the members' needs in the most cost-effective, consumer preferred setting or option.
- **How can MCOs improve access to transportation for SoonerCare members?**
  Transportation is critical for successful health care outcomes. Ride share options, such as Uber, are not always accessible or member friendly. Coordination of transportation services is needed.

Stakeholder Input: Quality and Accountability

- **What mechanisms should the state use to incentivize MCOs to improve member outcomes?**
  MCOs must meet targeted goals in order to receive their full payment or this program will never succeed. Incentive payments should be based upon improved health outcomes beyond minimum requirements.
- **What are the most important indicators of MCO performance**?
  This would be improved health outcomes and member and provider satisfaction. Cost savings should not be a primary factor as that will be a more long range benefit of any successful program.

Stakeholder Input: Care Management and Coordination

- **How can MCOs improve the management and coordination for member with chronic and complex health care conditions?**
  First, improving the quality of life for other members will reduce these cases in the future. But to address the current members with these conditions, it has been shown that additional nursing oversight and interventions can reduce costly health care expenses. Nurse practitioners should be involved for better case management and nursing interventions.

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Member Services

- **What metrics should be used to measure MCO performance?**
  Among the wide variety of metrics that should be utilized are access to care and evaluating the timely resolution of any member issues or concerns.
- **How can MCOs best communicate with members who do not have a mobile phone, etc?**
  The MCO must have a fully and competently staffed 24/7 help line for members to call. Many members are not comfortable with the use of technology.
- **How can MCOs communicate with members and receive input and feedback?**
  Every member must have ongoing communication with their case manager who can in turn share the members' feedback. Then there should be a third party "consumer protection" type program so any member at any time can share their thoughts and concerns and have a means for someone to immediately address any concerns.

Provider Payments and Services

- **Should OHCA require MCOs to maintain a minimum level of reimbursement?**
  Inadequate provider reimbursement will never develop the care system that will yield health care improvements. Minimum payments must be set for "any willing provider" with incentive payments for improved health outcomes. Payments should be set, at a minimum, at the current provider reimbursement rate, adjusted annually for inflation and include any unexpected, necessary expenses.
- **What provider services functions or process should be standardized?**
  Staff positions and staffing levels
- **What can OHCA and MCOs do to prepare and help providers to successfully participate?**
  There should be incentives for quality care and improved health outcomes.
- **How can MCOs support primary care providers?**
  Provide quality incentives for improved performance and ensure adequate provider rates for successful operations

Network Adequacy

- **How should MCOs work with providers to ensure timely access to care standards are met?**
  MCOs should have quality assurance staff to monitor the care systems to avoid any adverse outcomes.
- **How should MCOs recruit more health care providers?**
  If the MCO has the resources to partner with the providers for improved healthcare outcomes and they provide adequate reimbursement, provider recruitment should not be an issue.

Grievances and Appeals

- **How can MCOs and the state receive feedback and be accountable for addressing member concerns?**
  Again, there would need to be a third-party consumer protection type program to be the intermediary for members complaints and concerns, with 24/7 access by the members, such as with a toll-free hotline. There should be a penalty for the MCO based on excessive complaints

Administrative Requirements

- **How can MCOs help identify member and provider fraud?**
  Provider audits should be done to monitor the program compliance and the member services.

MyHealth® ACCESS NETWORK

To the Oklahoma Health Care Authority,

Re: Planned Comprehensive Medicaid Managed Care Implementation 80720200002

MyHealth Access Network, Oklahoma's Health Information Exchange (HIE) connecting Oklahoma health care stakeholders across the state, respectfully submits our feedback on the SoonerCare Comprehensive Managed Care Program design. Having spent the last 11 years linking together payers, providers, and other health care organizations across the state, MyHealth is committed to improving health outcomes by supporting care coordination and the exchange of valuable health information. MyHealth knows the value of data analytics in value-based payment programs through our involvement together in the CMS Comprehensive Primary Care Initiative and CPC+ Programs since their inception in 2012 as well as our work together on the Accountable Health Community Program.

Responses to questions concerning benefits provided through MCOs

- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

The integration and coordination of services is a consistent challenge in health care that community-based HIEs are adept at solving. Through services such as real time exchange of continuity of care documents (CCDs), admission, discharge, transfer notifications (ADTs), and an EHR-neutral provider portal, HIEs improve provider communication and data sharing. For this reason we believe that MCOs should be required to connect to the HIE as both data providers and consumers. The availability of claims data to the HIE is critical for helping providers better plan and coordinate care and learn from the outcomes (cost, utilization and clinical quality) their treatment and referral decisions achieve. This is also an important way for OHCA to obtain a continuous independent monitoring and evaluation of the performance of the MCO's and the overall program.

- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

MyHealth supports OHCA's decisions to require MCOs to engage in Social Determinants of Health strategies. Through MyHealth's work on the

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Accountable Health Communities Program, a CMS initiative that identifies and seeks to address unmet social needs among Medicaid and Medicare beneficiaries, we have seen the value of including Social Determinants of Health strategies in the continuum of care. To address the challenge of tracking outcomes of referrals to social services, further expansion of the successful Accountable Health Communities program with MyHealth will enable continuous monitoring and survey of the target population for social needs. As Social Determinants of Health are utilized more and more by providers and payers, the need grows for a robust system that can provide this information to stakeholders along the continuum of care. The Route 66 Accountable Health Communities program has already established the needed connections, policies, relationships and technology to enable widespread screening for social needs as well as addressing them and providing data needed for program planning and adjustment.

Responses to questions concerning Quality and Accountability

- What measures of health outcomes should be tracked?

Through MyHealth's work with both payers and providers as part of the CPC and CPC+ Programs we have worked extensively with value-based care measures. When selecting health outcomes worth tracking, we suggest OHCA leverage the Healthcare Effectiveness Data and Information Set (HEDIS) measures published by the National Committee for Quality Assurance (NCQA). In addition to the specific measures listed by the state in the RFI, we believe there is value in tracking a non-disease specific measure of health outcomes such as the 30-day all-cause hospital readmissions rate. CMS has already contacted OHCA about participating in a pilot program to work with HIE to become among the first Medicaid agencies in the nation to successfully report electronic HEDIS measures on their entire population. This will only be possible in an MCO model if the claims data is co-located with the clinical data in a setting like the Health Information Exchange.

Responses to questions concerning Care Management and Coordination

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

The key to consistency in utilization management, is consistent tracking of utilization information. This is accomplished through utilization tracking that is seamless and minimizes requirements for additional provider input so as to not distract from care. For this reason, we believe that utilization metrics are best compiled from existing health information at the HIE level. As an EHR-neutral solution, HIE utilization measures encompass the diversity of health providers that may be a part of an MCO and present results in a single digestible format. In addition, with new upgrades to support FHIR interoperability, MyHealth will enable support for the DaVinci project objectives, which enable health plans to query directly for the information needed from clinical settings to support utilization management, quality improvement and other use cases, while minimizing the burden on providers. Therefore, we believe the state should not only require MCOs to participate in the HIE, but also encourage them to leverage the HIE to aggregate applicable utilization measures and utilize the offered interoperability programs.

- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

MyHealth supports OHCA's redesign of the Patient Centered Medical Homes that includes integration of behavioral health and social determinants of health. As discussed earlier, HIEs provide a valuable role in care coordination; this is especially true of behavioral health.

While different care coordination approaches may be relevant for specific populations, the use of an HIE should be part of any approach that seeks to integrate behavioral health given the unique regulatory requirements of this information. Established HIEs, with already defined governance structures that are inclusive of behavioral health, regularly facilitate care coordination while honoring the unique privacy requirements of behavioral health information. MyHealth already connects the vast majority of behavioral health providers in the state many of whom utilize MyHealth on a daily basis to coordinate care and services for their patients.

- How can MCOs improve the management and coordination for members with chronic or complex health conditions?

Care coordination for chronic and complex health conditions often involves a diverse range of care providers besides primary care and hospitals, such as long-term care, rehabilitation services, home health, and optometry. This further demonstrates the value of MCO participation in a statewide HIE that is connected to the full spectrum of health services in the state. With that said, this care coordination is most effective when all parties have the same requirements and standards. Therefore, we suggest that OHCA also incentivize post-acute care and long-term care providers to participate in any care coordination activities that are required of MCOs, such as the state HIE.

- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

To improve care coordination IHS/Tribal facilities and non-IHS/Tribal facilities can enter into care coordination agreements to provide services that are eligible for enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Connecting MCOs to an HIE not only improves care coordination for AI/AN members, leveraging an HIE for information exchange is specifically listed in CMS State Health Official letter SHO #16-002 which describes the requirements for 100 percent federal matching. This positions the State of Oklahoma to save money while doing more for our most vulnerable populations.

Responses to questions concerning Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

By requiring MCOs to participate in the state HIE, OHCA is already taking a valuable step toward streamlining data sharing. With that said, robust data sharing must not come at the cost of patient privacy and information security. Maintaining both privacy and security

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requires a well-developed governance process. MyHealth's 10-year track record of effective HIE governance has included more than 1,000 volunteers from Oklahoma's hospitals, clinics, payers, agencies, tribes, etc. who have together donated more than 15,000 hours of service. These efforts have produced a non-profit HIE with a high level of trust across the state and a positive reputation nationally as well. This will enable the MCO's to join an established HIE that can draw upon the wealth of privacy and security knowledge of its participants when exchanging data, and also enable them (and the State) to count on the HIE as a trusted partner for secure, safe information exchange.

- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

While we believe required participation in a statewide HIE will help improve data sharing, we also recognize the financial burden associated with doing so, especially among rural and smaller health practices. For this reason we believe that OHCA and the state should continue to invest in the technical infrastructure of rural health care providers. HITECH funds can be used until the end of FFY2021, but other programs cited elsewhere in this letter can be leveraged to fund the infrastructure as well and MyHealth stands ready to support the pursuit of programs and funds to support those providers most at risk. Updating systems for these providers will not only improve care coordination but also help maintain/expand telehealth availability, both of which are goals of the proposed MCO Program

We appreciate the opportunity to provide feedback on the proposed program. For follow-up questions please contact MyHealth's CEO, Dr. David Kendrick at david.kendrick@myhealthaccess.net.

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David C. Kendrick, MD, MPH
Chief Executive Officer

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

Planned Comprehensive Medicaid Managed Care Implementation

On June 18, 2020, Governor Kevin Stitt and Oklahoma Health Care Authority (OHCA) CEO Kevin Corbett announced that the state would seek proposals from qualified managed care organizations (MCOs) to improve health outcomes, increase access to care, and increase system accountability in the Medicaid program (SoonerCare). The Request for Proposals (RFP) is currently in development, with a planned release this fall and an anticipated implementation date of October 1, 2021. OHCA is establishing requirements and is seeking stakeholder input prior to finalizing the RFP. OHCA will accept responses from any interested party including individuals and program participants, providers, trade associations, companies and other organizations. Responses need not address every question. Responses should be submitted by 5:00pm Central Time on August 17, 2020. Responses should be submitted via email to Procurement@okhca.org and can be submitted as a letter attachment. Please reference 80720200002 in the subject line of your response.

Comprehensive Managed Care for Oklahoma: A Key Tool for Program Improvement

Oklahoma is pursuing a comprehensive Medicaid managed care approach that will allow the state to achieve its payment and delivery system reform goals:

Improve health outcomes for Oklahomans

Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume

Improve member satisfaction

Contain costs through better coordinating services

Increase cost predictability to the state

The following sections provide information on the planned managed care program and identifies areas where additional input is requested.

1. Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid
- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting
- MCOs will serve members across the state
-

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?

  The transition should take place once a proper review of the program is completed based on KPIs (key performance indices) created by the team. After completion of the evaluation, a phased transition should take place given the program is successful.

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in

foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

Allowing MCO's to enroll all population would serve the purpose of the program. Selecting a focused group can get complicated as there won't be any choice for the members to choose what fits the best for them. Divisions can be created within the MCO to have specialty plans for the members to choose from.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Using various technology available and by providing small incentives. Technology such as interactive app to track all the progress, interactive text message service, automated voice call service, sending seasonal mails, interactive prerecorded videos through the app, etc. Incentives could include but not limited to lowered copay for next 5 visits after 10 successful visits, no ER or IP visits in a year could get reduced premiums or Rx coupons, reduced health maintenance programs or gym memberships for tobacco free for a year, sending grocery coupons if a target weight or lab value is achieved etc

2. Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services

- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers
- Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

  A streamlined and efficient workflow that allows easy communication and data transfer with the providers. Scheduling tools should be made available for the MCO's for easy same day appointment scheduling options, and a connected portal for data sharing with the providers to view the notes and make suggestions through the portal.

- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

  The major challenge will be the integration of EMR and health information of enrollees in a single accessible database with a friendly user interface. This database will then include a front-end portal for the physicians to share care plans, assessments, communicate with behavioral and physical service providers.

- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

  Having in-state and location-based case managers in the MCO will be helpful in assisting with various social needs such as housing, food security etc. Creating a research team that would do exclusive study on the assessing the MCO's strategies using measurable KPIs.

- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

  N/A

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

  Back-to-school programs, spring-cleaning, summer camp health events, health awareness month, healthy football season etc. can be some value-added program that can be formulated by the MCO. Semi-annual member and provider satisfaction survey can be used to assess the program and do potential improvements.

- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

  If an MCO can execute a subcontract with Uber &/or Lyft that allows for easy communication with drivers regarding non-acute medical transports and the MCO can establish a level of accountability with drivers for failed transports it could work very well. However, if either of these two components cannot be fulfilled it will not likely yield measurable positive results. Ride sharing could be a good option, but only if it can be monitored & a measure of accountability for drivers can be established to mitigate multiple riders with conflicting health concerns. Providing a ride system for each provider location dedicated for a zip code will be a possible solution as well.

3. Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as **state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**
- MCOs will **reimburse providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions
- **OHCA is investigating the use of incentive measures, quality pools and other programs;** MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?

  Monetize positive outcomes related to member improvement in stratified outcome measures for specific health conditions. Include four or more acceptable levels of improvement for specific diagnoses (e.g. top 10 diseases of Oklahomans) and a corresponding incentive. Example; 4 outcome levels of COPD management with 4 accompanying levels of incentive based payouts:

  - Level 1 = Increased understanding by member of disease progression coupled with measured medication compliance; $2 pmpm
  - Level 2 = Increased number of clinic visits to PCP of specialist (decrease # of clinic No-Show appointments); $4 pmpm
  - Level 3 = Measured decrease in the number of visits to Emergency Dept. for acute exacerbations (< 2 per year) for severe chronic conditions, followed closely by a similar decrease in hospitalization rates or re-admission rates (< 2 per year), $6 pmpm
  - Level 4 = No ED visits or IP admissions for 12 months or more; $8 pmpm

- What are the most important indicators of MCO performance? Why?

  Patients-provider engagement will be most important. It will lead to improvement of secondary measures mentioned below

- What measures of health outcomes should be tracked?

  Measures such as number of ER visits PMPM (per patient per month) before and after the program, number of goals met during the program, number of successful visits scheduled, achieved target lab, weight values.

  Number of contacts prior to member/patient engagement. Goals for member/patient after engagement. Progress of member/patient goals. Number of contacts during engagement as a measure for successful goal achievement.

4. **Care Management and Coordination**

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- **Conduct health screenings** to identify ongoing need, current providers, and social determinants of health
- **Develop care plans** for identified enrollees and **establish care management and care coordination** based on identified risk and particular health conditions
- **Design health management programs** with a holistic approach to member health
- **Conduct health education** in priority areas and on emerging issues

In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?

  Use a data-driven approach will support both parties. Having a predictive-modeling approach with flags and risk identification can be a potential solution

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

  MCO's should require & provide (Free of Charge) education to provider groups about the UM process works, especially within their MCO guidelines as they may be different from another MCO. Then provide evidence of such training to OCHA, OSDH, and State of Oklahoma Commissioner of Health.

- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

  N/A

- How can MCOs improve the management and coordination for members with chronic or complex health conditions?

Use the universal database approach to make appropriate care plans and have goals accordingly

- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

  N/A

5. Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- **Answer member questions timely** via telephone or email and resolve grievances and appeals timely
- **Frequently update provider directories** online to help members locate health care providers
- **Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?

  Metrics such as successful engagement with the case-manager and the provider, increased PCP visits, increase in overall health, active engagement in health programs, compliant in taking medications, reduced non-emergency ER and IP visits.

- How can MCOs best serve individuals who primarily speak a non-English language?

  Have a team with trained case-mangers who can speak different foreign languages. Prepare materials in the foreign language for better communication.

- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

  Use of interactive app-based system with advance tracking technology to track all the progress, interactive text message service, automated voice call service, interactive prerecorded videos through the app, map-based resource finder, quick health tips and guides in the app etc.

- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

  Have a team deployed to identify the member's location and provide them with materials about the program. Mail-outs can be an option given the situation. Conducting a large health fair for all the members and advertising it on TV. Mobile-health service in areas where more of the target population exists.

- How can MCOs communicate with members and receive regular input and feedback on program improvements?

  Using technology and an interactive app-based approach or through PCP visits

- What tools and resources would help members search for providers?

  Through the app developed for the program or comprehensive location-based list mail-out

  What information should be provided?

  Contact information, services provided, ride information etc

6. Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?

KPI measures such as, increased PCP visits, reduced no-shows, increase compliance, increased screening and immunization rates, increased patient engagement, reduced non-emergency ER and IP visits can be used

- Should OHCA require MCOs to maintain a minimum level of reimbursement?

  Yes, at a minimum should be same as level/s est. by OHCA now.

  How should this be accomplished?

  Same as OHCA conducts now.

  How should the state sustain provider compensation?

  Maintain compensation as is currently or require MCO to share cost.

- What is appropriate for timely payment of claims?

  Same as est. by OHCA, bi-weekly

- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

  N/A

- How can MCOs best communicate to providers about updates and changes to plan policies?

  Conduct monthly or bi-monthly meetings with the providers

- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

  N/A

- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

  N/A

- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

  N/A

7. Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

- Examples of industry standards include:
  - Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
  - Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
  - Require all Primary Care Providers have at least some same-day acute care appointments
  - Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)

- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?

  Monthly reports on standards evaluation should be sent to make any improvements and ensure timely access to care standards are met.

- What are reasonable time and distance standards in Oklahoma by provider type?

  N/A

- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

  MCO's can create a portfolio with success stories of implementation in the pilot phase to recruit more providers.

- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

N/A

8. Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

  An interactive feedback system or an online chat system will be an option to address the concerns quicker. Proactive approaches such as one-to-one feedback system which can record feedback immediately after the case-manager contacted the patient can be one of the solutions to address this issue.

- How can the state and MCOs use appeals data to improve utilization management and access?

  Doing extensive analytical research to find potential risk factors and high-appealing population which will lead to target based management approach can improve utilization management and access.

9. Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- **Gain accreditation** by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- **Maintain an Oklahoma presence,** including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work

- **Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

For effective management of members, it would be appropriate to share the entire EMR of the member. It would be easier to have an HIE (health information exchange) platform where all the member's health information can be viewed by the case manager for effective care. OHCA should include a clause in the enrollment privacy statement that it is authorized to provide any or all health information of the member if necessary.

- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

Setting up large servers to store all the claims and care management data could be challenging. Implementation of software like SQL servers, and having opensource reporting tools or licensed reporting tools will be a great way to send monthly, quarterly, and yearly reports to OHCA. Finding technical human resource with health-care data knowledge will be challenging as health data analytics is still a growing field. Setting up secure servers and portals for safe data sharing and having an IT team manage it could be a major challenge. To overcome some of these issues, OHCA and MCO should discuss with subject matter expertise that are handling these problems currently in the state.

- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

An integrated data system with all the transactions made by the member tracked in one system can be one possible solution. Flags and notifications for each transaction can be monitored via this data system. Fraud detection algorithms should be implemented within the system using data driven models to raise potential flags due to fraud. Like social security integration, Medicaid ID integration should be implemented to track every visit and encounter of the member to avoid frauds. Timely audits to providers can be another way to detect fraudulent transactions.

- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

  Given the fact that MCO and OHCA is successful in addressing issues like data sharing, transportation, care-coordination, integrated data system, improved health of members, successful action plans, provider and member engagement, the MCO can offer health plans in similar fashion on the Oklahoma Health Insurance marketplace.

Patti Davis
President

August 21, 2020

Kevin Corbett, Chief Executive Officer
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Submitted by email to: Procurement@okhca.org

RE: SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design
Reference 80720200002

Dear Mr. Corbett:

The Oklahoma Hospital Association (OHA) appreciates the opportunity to comment on the program design under consideration for coverage of the Medicaid expansion population and certain other relatively low-risk eligibility groups.

The OHA Board of Directors confirmed in a meeting this week their opposition to the outsourcing of SoonerCare programs and risk to private managed care organizations (MCOs). The Oklahoma Health Care Authority (OHCA) has already demonstrated the ability to administer an effective, low-cost Medicaid program while improving member outcomes. You will remember our joint meetings with the governor six months ago in which he supported building on the agency's care management programs instead of contracting out the delivery system. While some states may believe their Medicaid programs were improved by outsourcing to private MCOs, the situation and experience of Oklahoma is very different. Here, the introduction of Medicaid MCOs is likely to reduce member and provider satisfaction while increasing costs.

As an illustration, we refer you to recent coverage of a survey conducted by the independent Iowa State Auditor's office, examining Iowa's recent shift to Medicaid managed care. We urge OHCA to learn from Iowa's experience as it considers moving to managed care.[1] Eighty-three percent of Iowa hospitals responding indicated that they were dissatisfied with Medicaid MCOs, citing concerns about being paid in a less timely manner following the transition to managed care and having more difficulty settling claims.[2] Iowa's auditor recommended that the state consider establishing a single set of standards for approving services, coding claims, and processing claims

[1] Report on a Survey of Healthcare Providers Comparing Medicaid's Managed Care Model to the Fee-for-Service Model for the Period April 1, 2016 Through July 31, 2019, State of Iowa Office of Auditor of State, July 27, 2020, available at: https://www.auditor.iowa.gov/reports/file/62327/embed.
[2] https://www.modernhealthcare.com/medicaid/survey-shows-iowa-providers-dont-privatized-medicaid

as one strategy to minimize burden on providers. Earlier examinations of Iowa's experience showed that the 2017 transition to managed care led to an increase in disruptions in care and a 157% increase in complaints of care denials compared to the previous year, before managed care was in effect.[3] That analysis also highlighted how providers struggled to navigate the administrative complexity of the managed care model due to lack of transparency in MCO processes and payment delays.[4] Naturally, OHA has serious concerns about similar outcomes in Oklahoma. These problems are common in other state Medicaid programs that rely on MCOs, and would best be avoided by maintaining and further improving the state's current processes.

However, if the OHCA board is compelled by the governor to issue an RFP and award MCO contracts, careful study of adverse consequences in other states may inform guidelines that Oklahoma should consider in structuring the RFP and MCO contract. We offer comments in several of the areas identified by OHCA for input from stakeholders.

Provider Payments and Services

The state is seeking input about a range of provider payment issues:

- *What metrics should be used to measure MCO performance with regards to provider services?*

The state – in collaboration with providers and consumer groups – should establish robust reporting from plans on key data that can inform the state and the public on plan performance. Metrics could include measuring timely claims payment (including regular reporting of the percentage of "clean claims" paid on time) and timely response to provider appeals. The state also should require plans to operate a provider support line that is staffed with personnel trained on the requirements, policies and procedures of the plan operating in the Oklahoma market; staff should be able to respond to all areas within the provider manual, including resolving claims payment inquires.[5] The state should require the MCOs to measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary.[6] The state should conduct a provider satisfaction survey every other year and submit a written report of their findings, including the completion of any corrective actions.[7]

MCOs should be required to share regular, near-real time reports on denied claims, with a sufficient level of detail (e.g. specific service types) to understand where the denials are coming from and ability to compare denials across MCOs. The contract could establish a threshold that

[3] Iowa Office of Ombudsman. "Annual Report: 2017." April 2018. Available at: https://www.legis.iowa.gov/docs/publications/CA/961900.pdf

[4] Iowa Office of Ombudsman. "Annual Report: 2017." April 2018. Available at: https://www.legis.iowa.gov/docs/publications/CA/961900.pdf

[5] North Carolina Managed Care RFP, available at: https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf (see page 212 of PDF).

[6] See, for example, Virginia's Medallion 4.0 Managed Care Contract, available at: http://www.dmas.virginia.gov/files/links/2325/Final%20Expansion%20Amendment%20Medallion%204.0%20Contract%202018.pdf (see page 94 of PDF).

[7] *Id.* at page 95.

could trigger increased state oversight (maybe comparing to a national benchmark) and possibly some sort of dispute resolution process for hospitals and MCOs.

Tough penalties should be set for failure by MCOs to submit complete encounter data, including penalties if MCOs do not submit data to the State needed to calculate directed payment amounts or distribute the payments within a certain timeline.

- *Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?*

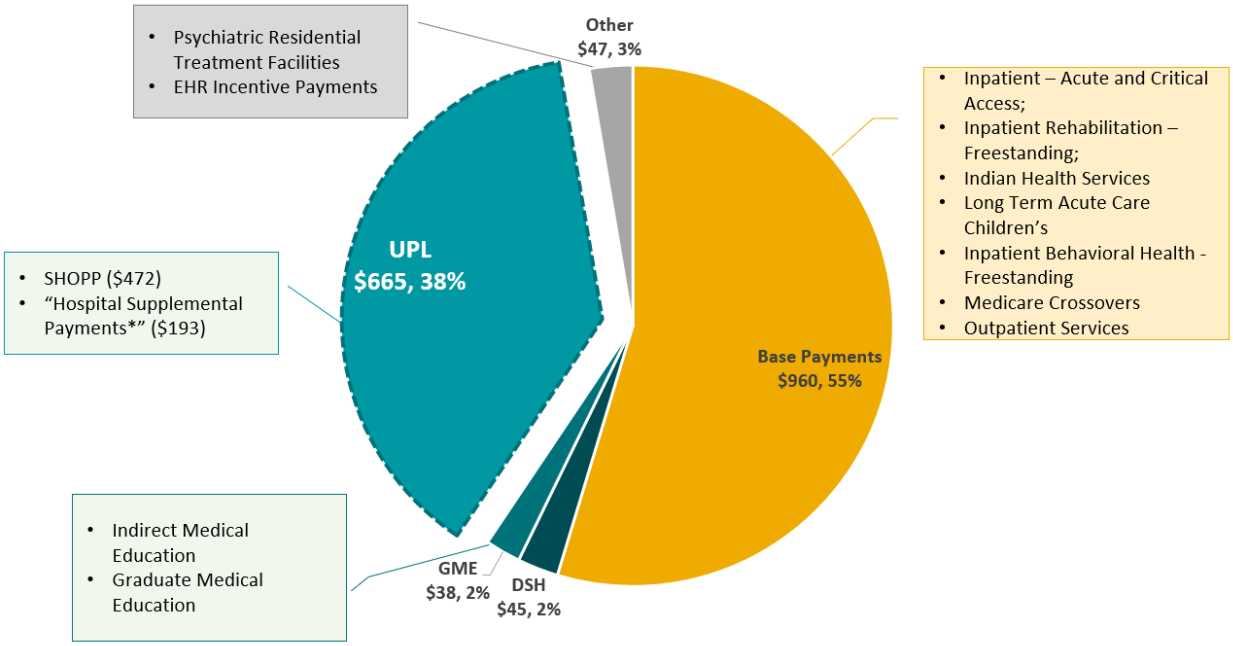
Oklahoma hospitals currently receive Medicaid reimbursement through a combination of claims and supplemental payments. Even with these supplemental payments, Medicaid reimbursement is lower than hospitals' costs of delivering care to Medicaid beneficiaries, especially when considering the cost of provider assessments to fund the supplemental payments. **As a result, the transition to managed care must, at a minimum, preserve current payment levels to hospitals to ensure access and quality of care for Oklahoma's Medicaid beneficiaries.** To accomplish this goal, the state should (1) preserve the value of supplemental payments, (2) prohibit managed care plans from setting provider payment rates lower than SoonerCare fee-for service rates, and (3) set managed care capitation rates at levels sufficient to maintain quality and access

Preserve Value of Supplemental Payments. Under the current Medicaid payment methodology, the state makes an array of supplemental payments to hospitals, including Disproportionate Share Hospital (DSH) payments; Graduate Medical Education (GME) payments; and the SHOPP and Teaching Hospital Reimbursement Program payments, which are made under Upper Payment Limit (UPL) authority and designed to reimburse hospitals based on a reasonable estimate of what Medicare would have paid for the same services based on Medicare payment principles.[8] In 2019, these UPL payments represented about 38% of Medicaid payments to Oklahoma hospitals.[9] It is important to note that state share for the upper payment limit program (SHOPP) is provided by 65 hospitals, not the state of Oklahoma.

[8] 42 CFR 447.202; 42 CFR 447.321
[9] http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24442&libID=23425

To illustrate:

Medicaid Payments to Oklahoma Hospitals by Type: SFY 2019 *(in millions)*



Federal regulations permit states to make UPL payments for Medicaid fee-for-service utilization only. As a result, Oklahoma will *not be permitted* to make payments under UPL authority for Medicaid beneficiaries enrolled in managed care. The state has indicated that a significant number of Medicaid beneficiaries will transition to managed care initially (e.g., children, low-income parents, pregnant women, expansion population), while some populations will initially remain in Medicaid FFS (e.g., ABD, duals, etc.). If this plan moves forward, the state's ability to make UPL payments would be significantly constrained and, without an alternative approach, could lead to substantial payment reductions for Oklahoma hospitals. Ultimately, if all of the SoonerCare population moves to Medicaid managed care, the UPL program could be eliminated altogether.

If Oklahoma plans to move to Medicaid managed care, it is critical that the state work with Oklahoma hospitals to develop strategies that maintain the full value of Medicaid hospital payments. Specifically, the state could transition a portion of payments currently made under the UPL to a managed care "directed payment", made consistent with federal regulations under 42 CFR 438.6(c), permitting the state to direct plan expenditures if such payments:

- Are directly tied to beneficiary utilization of services;
- Are directed equally across a class of providers (though states have flexibility to define the class);
- Are not conditioned on provider IGTs; and,
- Are linked to the state's quality strategy.

As one approach, the state could build a portion of payments previously made under UPL authority into managed care capitation payments. To ensure the higher payments actually reach providers, the state could implement a directed payment requiring MCOs to make minimum per-unit (e.g., inpatient discharge, outpatient encounter) payments ("rate floors") to providers in a specified class; or to make additional payments over and above standard per-unit rates.

States have substantial flexibility under directed payment authority to define the class of providers eligible for the payment (e.g., public, private, critical access hospitals); develop the payment methodology (e.g., a flat per-unit payment, percentage of the base rate, cost-based reimbursement etc.); and determine whether the payments are made as a rate adjustment with each claim or paid retrospectively based on actual utilization. All of these design choices have implications for preserving the aggregate value of hospital payments; the distribution of payments among hospitals compared to the current state; and the non-federal share financing (e.g., provider tax) approach. It is likely that several different directed payments may be required for different classes of hospitals (e.g., PPS, critical access hospitals) to reflect the different ways such hospitals are currently reimbursed and ensure that (especially vulnerable) providers are not destabilized.

The state should work collaboratively with hospitals to develop an integrated payment methodology that maintains hospital payment levels and minimizes the distributional impact of changes to the payment methodology, ensuring Oklahoma hospitals can continue to effectively serve Medicaid beneficiaries after the managed care transition. This work should be completed, adopted as legislation, and approved by CMS before the state issues any requests for proposal for Medicaid MCOs.

Set a Floor for Managed Care Claim Payment Rates. SoonerCare payment rates for hospitals are lower than those of any other payor, necessitating Oklahoma hospitals' dependence on supplemental Medicaid payments. The state can reasonably require managed care plans to use payment rates that are no lower than those set in current SoonerCare fee schedules. MCOs should not be given the ability to profit by taking advantage of desperate providers, who may be forced by a plan with enough market power to agree to further reductions in payment rates.

Ensure Adequate Managed Care Capitation Rates. The state should assure that MCO capitation rates are adequate based on current state experience and do not make overly aggressive utilization reduction assumptions. Artificially low capitation rates for plans will result in plans squeezing providers through inappropriate claims denials, which will jeopardize access and quality of care for beneficiaries.

- *What is appropriate for timely payment of claims?*

To preserve SoonerCare providers' financial viability, OHCA should require MCOs to pay claims within 15 days of receiving a clean claim (or within 15 days of receipt of requested additional

information),[10] and require plans to pay penalties and interest for claims paid after more than 30 days.[11] The state should require regular reporting of the percentage of "clean claims," since MCOs may seek to sidestep prompt payment requirements by concluding that a large number of claims are not complete. By monitoring, the state will be able to identify and correct any outlier plans. The state should impose sanctions on plans if they are determined not to be paying claims on time. Finally, the state also should have a dedicated liaison to providers to help address these types of issues in real time.

Again, Iowa's experience is instructive. There, administrative complexities and inefficiencies burdened hospital providers. Specifically, inaccuracies and delays in payment resulted in significant administrative burdens and fiscal impacts for providers. The Iowa Hospital Association found that claims denials were as high as 15% in some hospitals and that accounts receivable increased dramatically. Oklahoma should take steps to ensure that its managed care contract insulates against such delays in timely processing.

- *What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?*

The state should put uniform guardrails around utilization management, including a uniform definition of medical necessity, restrictions on prior authorization for critical services (e.g., primary care, behavioral health), and require that MCOs develop a utilization plan and submit it to the state for approval. The state also should require that MCOs use a nationally recognized decision support tool to guide utilization management decisions and publish clinical policies. (See further discussion of utilization management under "Care Management".)

Provider enrollment, prior authorization, and claims processing requirements also should be standardized across MCOs to diminish the administrative burden on providers and avoid unnecessary MCO administrative spending. The state also should establish a single credentialing process, requiring MCOs to rely on all Medicaid enrollment data/information that already exists within the state. Then, to the extent that additional information is required for credentialing (e.g., board certification etc.), the state should set forth a centralized credentialing process whereby providers only need to supply that additional information once. Georgia may be the best and most feasible model – it has a one-stop centralized credentialing program that does both Medicaid enrollment and plan credentialing.[12]

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[10] Federal requirements at 42 CFR 447.45(d) define timely claims processing as the agency paying 90 percent of clean claims within 30 days of receipt; 99 percent of clean claims within 60 days, and all claims within 12 months (subject to limited exceptions). Oklahoma could impose more stringent requirements, as do other states. See, e.g., North Carolina Managed Care RFP, available at: https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf (see page 245 of PDF).

[11] *Id.* at 246; see also Virginia's Medallion 4.0 Medicaid Managed Care Contract, http://www.dmas.virginia.gov/files/links/2325/Final%20Expansion%20Amendment%20Medallion%204.0%20Contract%202018.pdf (page 96 of PDF).

[12] https://dch.georgia.gov/providers/centralized-cvo

In addition, the state should ensure that incident reporting procedures are consistent with state and federal protections for peer review process and use of medical review committees. The state should also standardize quality metrics and reporting procedures for some domains, while leaving some discretion for plans to add additional metrics. (See below for additional discussion of "Quality and Accountability".)

Iowa's experience is relevant here as well; variation and delays in processes across plans (e.g., credentialing, service descriptions, utilization management, coding) contributed to provider dissatisfaction as the state implemented its managed care program.[13]

- *How can MCOs best communicate to providers about updates and changes to plan policies?*

The state should require plans to make current policies (including but not limited to the Provider Manual) available and updated on the provider portal of each managed care plan's website at all times. With respect to changes, the contract should require plans to provide appropriate advance notice (e.g., at least 90 days) via each plan's provider portal. In addition to posting plans and plan changes on the provider portal, plans should also provide either a mailed letter or email notification, based on each provider's communication preferences. The state should hold regularly scheduled webinars (e.g., once per month) with plans to communicate any contract changes to providers (e.g., covered services or new reimbursement policies, such as new directed payments).

- *How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?*

Standardizing prior authorization policies/processes and claims filing procedures – as well as criteria used to approve or deny claims – will help reduce administrative complexity and will reduce costs across the health care system. For example, MCOs should limit the number of addresses for claims submissions to reduce the potential for unnecessary burden and provider payment delays (e.g., addresses for medical claims, lab, and pharmacy claims could be separate but only one address for each). This administrative simplification will help providers navigate plan requirements and – coupled with timely claims filing requirements – help assure prompt payment of claims. As described above, a robust provider services hotline and provider portal are other critical supports for network providers.

- *What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?*

[13] Report on a Survey of Healthcare Providers Comparing Medicaid's Managed Care Model to the Fee-for-Service Model for the Period April 1, 2016 Through July 31, 2019, State of Iowa Office of Auditor of State, July 27, 2020, available at: https://www.auditor.iowa.gov/reports/file/62327/embed.

The state should work with hospitals, other health care providers and stakeholders to adopt quality metrics to evaluate MCOs and then ensure payment levels are sufficient to promote access to quality care, as discussed above. Shared accountability models that reward providers for quality and improved outcomes should be developed in collaboration with stakeholders and informed by initial managed care experience in Oklahoma.

Care Management and Coordination

OHCA is seeking input on a number of design questions that are of critical importance to OHA and will influence hospitals' experience with managed care and, in turn, beneficiaries' experiences and health outcomes.

- *How can utilization management tools work best for members and providers?*
- *How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?*

OHCA states that it is developing state requirements and standards for MCOs regarding prior authorization (including services subject to prior authorization and timeliness standards for approval), use of practice guidelines, and utilization management program standards. These standards should be applied uniformly across all plans to reduce provider burden. As discussed above, OHCA should require that all MCOs that it contracts with use standardized decision support tools and approaches so that providers do not need to learn multiple systems/rules. Oklahoma also should prevent plans from imposing plan-specific medical-necessity/clinical criteria in excess of criteria already used by Oklahoma Medicaid.[14] Iowa's recent experience underscores the difficulties that providers have when different plans have different requirements; such variations lead to administrative complexity for providers and can undermine access to care for beneficiaries.

Unchecked utilization management will have a negative impact on beneficiaries' access to services. The state should also set limits on MCO utilization management and develop a plan to oversee MCOs in this regard. **Robust public reporting requirements on claims denials is imperative; the state should closely monitor rates of denials to identify any outlier plans/service lines;** similarly, the state should monitor rates of claims that are down-coded. Such safeguards will prevent MCOs from inappropriately denying claims to reduce utilization and keep their spending down. Secondary reviews should be conducted by a specialist independent of the health plan who practices in the same clinical specialty field to assure that the best medical expertise is applied to each case. The contract also should specify that the determination of whether a condition is an emergency medical condition and when such condition has been stabilized shall be made by the treating physician. In addition, the contract should specify that plans must cover the entire cost of a hospital stay, if a beneficiary is enrolled during the hospital stay.[15]

[14] See, for example, the approach proposed in North Carolina Managed Care RFP, available at: https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf (see page 147 of PDF).
[15] Amendment to North Carolina Prepaid Health Plans Services Contract, available at: https://files.nc.gov/ncdma/Contract--30-190029-DHB-PHP-Amendment-1.pdf (see page 8 re: Section V.C.4.c.viii).

Finally, the state should prohibit retrospective reviews of any services that were subject to prior approval. In addition, the contract should specify that, in the event a procedure has been authorized, the plan may not deny or otherwise penalize providers for any change in such care, including but not limited to a change in the procedure or provision of additional procedures. The state also should require reporting on the share of retrospective denials to identify and address high denial rates, which will be difficult for hospitals to sustain.

- *How can MCOs improve the management and coordination for members with chronic or complex health conditions?*

OHCA's support for patient centered medical homes to support integration of behavioral health and social determinants, enhanced care coordination payments, and payment measurement are all key elements of a strategy to improve care management and coordination for members with chronic or complex health outcomes. This process must ensure that the right care is being provided in the right place at the right time.

Enrollees

- *How and when should OHCA transition ABD and other initially excluded individuals to managed care?*

In recent years, both Iowa and Kansas implemented managed care on particularly aggressive timelines, and both states experienced large disruptions in patient care. Kansas was cited by CMS for non-compliance with federal Medicaid statute and regulations and noted particular concerns about the lack of stakeholder engagement, state oversight of MCO activities, and reduced access to care.[16] By comparison, Texas implemented managed care plans in a phased approach over several years (beginning with acute and primary care services for women and children, and eventually expanding to cover additional populations such as the aged, blind, and disabled).[17] Ohio also implemented managed care plans in phases by region, while allowing some populations to enroll voluntarily (e.g., foster children).[18] These two states are generally regarded as having had more successful transition experiences and Oklahoma should follow a similarly thoughtful, phased approach to implementation.

Also, Oklahoma's Medicaid MCO in the 1990s allowed enrollees to choose their own MCO. However, if the patient failed to make a choice, the OHCA auto assigned the patient to a physician.

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[16] Centers for Medicare & Medicaid Services, "Letter to Kansas Department of Health and Environment." January 13, 2017. Available at: http://www.kha-net.org/CriticalIssues/KanCare/Tools/KanCareAdministrativeResources/d137648.aspx.

[17] Centers for Medicare & Medicaid Services. "Managed Care in Texas." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/texas-mcp.pdf

[18] Centers for Medicare & Medicaid Services. "Managed Care in Ohio." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/ohio-mcp.pdf

This resulted in family members being assigned to different primary care physicians in the service area. This was a huge dissatisfier for the patients as well as an administrative nightmare for physicians. We do not need to learn this lesson again.

Network Adequacy

- *How should MCOs work with providers to ensure timely access to care standards are met?*

To ensure network adequacy, the state should implement reasonable time and distance standards (see below), develop appointment wait-time standards, and require plans to assure that they will contract with any willing provider. Networks must be broad enough to minimize disruption in care as the state moves from fee-for-service to managed care. The state could implement corrective actions, fines, penalties and/or sanctions if MCOs do not build and maintain adequate networks that comply with federal Medicaid requirements. MCOs should be prohibited from financially penalizing non-network participants who provide care to Medicaid enrollees who seek care outside of the network.

Oklahoma also can take a variety of other steps to ensure that networks are robust. For example, as noted above, the state should streamline credentialing so that providers do not have to credential with each MCO and credentialing requirements should not exceed those of Oklahoma's current Medicaid program. Oklahoma also could direct plans to deem providers that are participating Medicare providers to be eligible Medicaid providers.

- *What are reasonable time and distance standards in Oklahoma by provider type?*

The state should require that in urban areas there is at least one hospital within 30 minutes or 15 miles, and in rural areas there is at least one hospital within 60 minutes or 60 miles. To promote access, the state could consider applying time and distance standard to providers beyond those required under managed care rules.

- *How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?*

Ensuring that rates are adequate is a key step to recruiting a robust provider network. In addition, OHCA should encourage the participation of home-grown, provider-operated plans that can rapidly build comprehensive provider networks.

Quality and Accountability

- *What mechanisms should the state use to incentivize MCOs to improve member outcomes?*

To help improve member outcomes, the state could require MCOs to extend quality incentives to providers, who can most directly drive such improvements. For example, the state could create a quality incentive pool that MCOs must pay down to high-performing providers and hospital

systems.[19] The state also could consider setting value-based payment (VBP) targets for MCOs, based on the Health Care Payment Learning & Action Network (HCP-LAN) framework, which requires that a certain percentage of medical payments be in VBP initiatives.[20] The percentage could phase up over time.

- *What are the most important indicators of MCO performance? Why?*

Beneficiary input is a key way to gain an understanding of MCO performance. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a widely-used survey that helps identify strengths and weaknesses in patients' experience and evaluate the effectiveness of interventions to improve patients' experiences. For example, if beneficiaries experience a large volume of denials of service, the CAHPS survey is likely to reflect such concerns. Other states use the CAHPS survey to measure consumer experience with their Medicaid managed care plans.[21]

If the state is interested in developing a more robust quality monitoring strategy for plans, it could look to Oregon as a model. Oregon recently developed the Transformation and Quality Strategy (TQS)—an innovative data collection, analysis, and follow-up system. Plans will develop their own TQS and provide the state with their strategies, activities, processes, and procedures related to the required quality assessment. Additionally, plans are required to send an annual TQS Progress Report to update Oregon on current and on-going activities for process improvement, effectiveness and progress toward achieving Triple Aim goals, barriers encountered and overcame in achieving goals, and follow-up strategies or actions to support continued progress.[22]

Regardless of the approach that the state adopts, it is important to select standard measures and apply them consistently across plans. Once the measure set is agreed upon, results should be released publicly so that beneficiaries and stakeholders can compare plan performance.

- *What measures of health outcomes should be tracked?*

The state should set up a collaborative process to identify the appropriate outcomes to measure health outcomes initially and on an ongoing basis; a community advisory board could help guide the selection of priority measures. The state should select standard measures, apply them consistently, and publicly report to facilitate transparency and uniformity of data so that

[19] Over time, the state could consider transitioning to a quality withhold program, which can function in the same way but only if capitated rates are high enough to sustain a withhold. For example, if rates are sound, the state could build-in a 3% profit margin and then withhold payments subject to plans and providers meeting established metrics. Quality withholds are generally preferred in more mature managed care ecosystems with at least several years of rate-setting experience.
[20] For more information, see: https://hcp-lan.org/.
[21] See e.g., Iowa (https://dhs.iowa.gov/sites/default/files/CAHPS-Iowa_vs_National_Average.pdf?080820201729); New York (https://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report/2018/); Texas (https://www.molinahealthcare.com/members/tx/en-US/mem/medicaid/star/quality/cahps.aspx);
[22] See Oregon's Model Contract, available at: https://www.oregon.gov/oha/OHPB/CCODocuments/Updated-draft-CCO-contract-terms.pdf (beginning on page 123).

beneficiaries and stakeholders can compare health outcomes across plans. Included in this process should be reporting of health improvement of individuals as well as the cost savings to the state of Oklahoma.

Grievances and Appeals

OHCA intends to ensure that MCOs meet OHCA and federal requirements for timely and meaningful grievances and appeals. Since grievances and appeals may be filed by providers on behalf of members, OHA has an interest in encouraging the state to establish streamlined processes.

The RFI does not specifically ask for input about the Grievances and Appeals process from the provider perspective, but the state should establish requirements that plans handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and OHCA requirements. The contract should require that plans have in place a provider appeals and grievance system (distinct from that offered to Members) that includes a grievance process for providers to bring issues to the plan, an appeals process for providers to challenge certain PHP decisions, and information regarding access to a state level review. The plans should establish reasonable timelines for provider appeals (e.g., 30 days from notice of an adverse decision) and for written notices of decision of the appeal (e.g., 30 days after receiving a complete appeal request).[23] It would be preferred that the MCO has a physical location within the state, which would provide opportunity for interaction.

- *How can the state and MCOs use appeals data to improve utilization management and access?*

Transparency with respect to appeals data is essential to permit the state to assess MCO performance. Robust, regular reporting requirements will enable the state to identify outliers among the plans in terms of denials and grievances, for example. With respect to utilization management in particular, appeals data provides an important lens for the state to determine if beneficiaries are receiving appropriate services without needless delays. Transparency in data also will enable the state to determine whether utilization management procedures are impeding access.

Other: Indian Health Service, Tribal and Urban Indian Health Systems

OHA understands that the state has been working with the Indian health systems in Oklahoma and that several Indian health systems have responded with their comments. The OHA supports the Indian health system in Oklahoma and encourages OHCA to implement their recommendations, as they understand the nuances of their systems better than anyone. It is critical that the state does not jeopardize any of the 100% FMAP funding they receive for care provided by and through the Indian health system.

[23] See, e.g., North Carolina's model contract, available at: https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf (see page 225 of PDF).

Conclusion

The Oklahoma Hospital Association fully supports the state's efforts to improve the health of Oklahomans, to improve health quality measures, and to control expenses. Those efforts are best served by building on the strengths of OHCA's current programs that manage care, not by outsourcing responsibilities to commercial managed care organizations. It is important to note the OHCA has always had much lower administrative costs to implement this program than would be the case in outsourcing to private managed care companies. This is an important comparison that should not be overlooked. In addition, health care providers across Oklahoma rely upon timely clean claim payments, which is typically within 14 days from the OHCA.

There is no clear evidence that outsourcing to MCOs saves states money or improves outcomes. Medicaid MCOs make billions in profits each year,[24] and add administrative costs in the tens of billions. And that money leads to powerful influence over state governments. If Oklahoma gives in to the pressure to outsource, we believe the state must address the areas outlined above. And most importantly for Oklahoma hospitals, we must be guaranteed that supplemental payment programs are in place to maintain hospital revenues and viability.

In addition, we think the suggested timeline for completion of the RFP, award phase, and enrollment, along with the necessary work to develop an integrated payment, is unreasonable.

We appreciate your consideration of these comments.

Sincerely,

Patti Davis

Patti Davis
President
Oklahoma Hospital Association

[24] "Medicaid Managed Care: Lots of Unanswered Questions (Part 1)," Health Affairs: https://www.healthaffairs.org/do/10.1377/hblog20180430.387981/full/

HEALTHY MINDS
POLICY INITIATIVE

Friday, August 21, 2020

Mr. Kevin Corbett
Chief Executive Officer
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, Oklahoma 73105
Procurement@okhca.org

Re: ***Public Feedback on SoonerCare Comprehensive Managed Care Program Design, reference number 80720200002***

Dear Mr. Corbett,

Thank you for the opportunity to provide feedback on the Oklahoma Health Care Authority's (OHCA) *SoonerCare Comprehensive Managed Care Program Design, reference number 80720200002* (MCO RFP).

Healthy Minds Policy Initiative (HMPI) is a non-partisan, non-profit organization addressing mental health and substance abuse policy issues to support policymakers, schools, law enforcement and community leaders with data-informed strategies that reduce poor outcomes for people with mental illnesses and substance use disorders, and the costly financial and social impact of these diseases on communities and the state. HMPI knows from data analysis and research that health care coverage and integrated care greatly improve the lives of people with mental health conditions or substance use disorders. As HMPI supports expanded health care coverage for individuals, and integrated care to better address the physical and mental health needs of Oklahomans with mental illnesses and substance use disorders, we wanted to share the following feedback about the proposed SoonerCare Comprehensive Managed Care Program Design, as presented.

Although commercial Managed Care Organizations (MCOs) have nationally demonstrated an ability to deliver positive outcomes for some populations, they have generally struggled to deliver outcomes for special populations, such as serious mental illness and substance abuse, foster children and developmental disabilities. This can be attributed to the inherent difficulty in managing complex needs in unfamiliar local systems; unique challenges for a commercial MCO model in maintaining network adequacy for behavioral health providers whose workforce pools,

geographic coverage and financial capabilities are already limited; and often a lack of understanding of or commitment to evidence-based care for more challenging populations. With approximately two-thirds of members experiencing access to specialty care issues, Oklahoma should take particular care to understand the track record of MCOs in generating outcomes for these populations. We also recognize that Oklahoma, a predominantly rural state with an elevated prevalence of poor health problems, may have unique sustainability challenges in a commercial MCO model. A relatively small statewide population with higher average costs would, in principle, create challenges to spreading risk evenly across multiple MCOs as necessary to ensure adequate market competition and appropriate networks of care.

Should Oklahoma move forward with a managed care model, Healthy Minds Policy Initiative would be committed to ensuring positive cost and health outcomes for Oklahoma taxpayers and residents with mental illness or substance use disorders. To that end, we offer the below overview of the attached considerations. Importantly, many of the standards and strategies we identify here can be implemented by the State to improve the physical and behavioral health of Oklahomans and achieve efficiencies with or without utilizing commercial managed care organizations; thus, it is our hope that these comments are helpful regardless of the model chosen by the State to pursue value-based care:

Enrollees

- Phase-in ABD population in five years, after having developed multiple years of provider networks to offer an adequate number of family and team-based intensive services. The State and MCOs must anticipate the behavioral health needs of current enrollees, and unknown behavioral health needs of the expansion population and provide a separate MCO for the specific needs of foster children.

Benefits

- Require MCOs to provide strong evidence-based behavioral health care models--like the Collaborative Care Model (CoCM), assertive community treatment (ACT), multisystemic therapy and intensive in home family-based therapies for children and contract with the NAVIGATE First Episode Psychosis program to provide Coordinated Specialty Care (CSC)[1] for the early treatment of psychosis in young adults and continue using telemedicine and telehealth in state plan services.
- MCOs should provide value-added and cost-effective services in lieu of more expensive services and use current measures for ODMHSAS provider networks for adults, children and youth.[2]

[1] Gingerich, S. (n.d.). *First episode psychosis and the NAVIGATE treatment model in Oklahoma.* www.oklahoma.gov/odmhsas/documents/fep%20and%20nav%20model-ok.pptx

Mueseer, K. T., Pen, D. T., Addington, J., Brunette, M. F.,Gingerich, S. et al. (2015, July). The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services, 66*(7): 680–690. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400413

[2] Oklahoma Department of Mental Health and Substance Abuse Services. (n.d.). *Enhanced Tier Payment System (ETPS) — pay for performance.* www.odmhsas.org/eda/etps/

Quality and Accountability

- Use the HEDIS measures. For BH conditions, build on the value-based purchasing approach of Oklahoma Enhanced Tiered Payment System.[3] Use the measures developed for the Oklahoma CCBHCs, which meet national standards and provide information for OHCA and ODMHSAS.[4]

Care Management and Coordination

- Require MCOs to assign utilization management staff knowledgeable on state plan services and array of evidence-based practices. Use standardized behavioral health care guidelines across MCOs, including ASAM patient criteria for SUD, follow length of treatment guidelines for evidence-based practice and parity requirements while using similar cost saving utilization strategies.

Provider Payments and Services

- MCOs should pay claims within 30 days; the State should encourage use of case rates and alternative payment methods and require payments no less than current FFS rates and ODMHSAS funding. Standardize credentialing across the MCOs by using a single application and Credentialing Verification Organization (CVO).
- Track the pending Medicaid Fiscal Accountability Regulations[5] for impact on the current Supplemental Hospital Offset Payment Program payments to facilities. [6]

Network Adequacy

- Require the MCOs to contract with safety net providers: Contracted ODMHSAS CMCH, Certified Community Behavioral Health Clinics, Oklahoma Systems of Care providers, and all licensed school-based mental health clinics within the MCO's service area. Conduct provider and stakeholder surveys to identify reimbursement challenges and rate adequacy.
- Use behavioral health industry standards: 1 hour for emergency care, 24 hours for urgent care and 14 days for routine care. Require same-day telehealth appointments and access to ensure timely care. Ensure providers are located in 30 minutes or 30 miles for urban and suburban areas and within 60 minutes or 60 miles in rural areas. The MCOs must assist providers to meet these standards by increasing provider capacity and offering support for evidence based strategies, such as telehealth appointments.

Grievances and Appeals

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[3] Fields, S., & English, K. (2011, December). *The Oklahoma Enhanced Tier Payment System: Leveraging Medicaid to improve mental health provider performance and outcomes*. National Association of State Mental Health Program Directors. www.odmhsas.org/eda/etps/The%20Oklahoma%20Enhanced%20Tier%20Payment%20System%20Final.pdf

[4] A list of the CCBHC quality measures (the first nine are measures at the behavioral health center level and the last 13 are measures at the state level) can be found at this link: .https://www.ok.gov/odmhsas/documents/CCBHC%20quality%20measures.pdf

[5] Rudowitz, R. (2020, January 27*). What you need to know about the Medicaid Fiscal Accountability Rule (MFAR*). Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/what-you-need-to-know-about-the-medicaid-fiscal-accountability-rule-mfar/

[6] Oklahoma Health Care Authority. (n.d.). *SHOPP hospitals.* http://www.okhca.org/providers.aspx?id=13568

- Establish a representative member advisory committee of individuals and/or families that utilize all levels of care to review MCO reports and trends on grievances and appeals. Require the MCOs to provide a monthly accounting of member grievances.

Administrative Requirements

- The State should require MCOs to share demographic, clinical and prescriptions information with providers. MCOs should assist BH providers with technology strategies for data sharing.

HMPI appreciates the opportunity to provide feedback on the proposed SoonerCare Comprehensive Managed Care Program Design. Please do not hesitate to contact us with any further questions on this matter.

Sincerely,

Zack Stoycoff, MPA
Executive Director
Healthy Minds Policy Initiative
Email: zstoycoff@healthymindspolicy.org
Phone: 918-500-0531

Attachments: *Healthy Minds Policy Initiative SoonerCare Comprehensive Managed Care Request for Public Feedback*

Healthy Minds Policy Initiative
SoonerCare Comprehensive Managed Care Request for Public Feedback

Healthy Minds Policy Initiative (HMPI) appreciates the opportunity to respond to the Request for Public Feedback (RPF) on Medicaid managed care. We have compiled responses to each inquiry in a manner that addresses industry-wide standards for Medicaid behavioral health managed care, using information from other states, the Centers for Medicare and Medicaid Services (CMS) requirements and accreditation organizations.

The standards presented by the Oklahoma Health Care Authority (OHCA) listed in the RPF under each section are consistent with best practices in managed care, with a few exceptions. We focus our comments on specific challenges and opportunities related to the care management of Oklahomans with mental health and addiction treatment needs. In general, we applaud the State for a strong recent history of care and cost management for behavioral health services, and we advise support for and continuation of these successes. For example, under the oversight of the Oklahoma Department of Mental Health and Substance Abuse Services' (ODMHSAS), annual cost growth for Medicaid's behavioral health line has been held virtually level with inflation for nearly a decade. Prior to ODMHSAS obtaining direct oversight of behavioral health Medicaid costs in 2012, these costs had increased 14 percent annually for a number of years.

In general, we also applaud the intent of managed care as represented in this RPF. However, we offer a number of cautions and risk-mitigation considerations should Oklahoma proceed with the proposed model. Nationally, commercial MCOs have not excelled at managing integrated care for special populations, such as serious mental illness and substance abuse, foster children and developmental disabilities. Substance use providers are often at particular risk for closure due to radical changes in administrative and funding structures. As a result, commercial MCOs can struggle to maintain adequate networks for addiction treatment, in particular. There would be a special concern with providers' administrative burden in transitioning to a commercial MCO model simultaneously with Medicaid Expansion, as providers would be asked to comply with new MCO requirements while increasing the number of people they serve. Providers would almost certainly need additional administrative support to meet the standards outlined in this document — particularly, funding to improve provider information technology for claims and quality reporting, and adequate rates to deliver evidence-based practices.

Moreover, as a small-population state with generally poor health outcomes, it is important to consider that Oklahoma may lack a sufficiently-large, relatively low-cost population to spread the risk evenly across multiple MCOs as necessary to ensure adequate market competition and appropriate networks of care. This would be a particular concern after enrolling the aged, blind, and disabled (ABD) population and other special populations that have higher associated costs

of care. It would not be difficult to impact a general collapse of commercial MCO model similar to that seen in Oklahoma during the 1990s.

Should Oklahoma pursue a commercial MCO model, we offer a number of considerations and recommendations to mitigate risks while improving the chances of positive health and cost outcomes. It would also be important to note that many of the standards and strategies we identify here can be implemented by the State to improve the physical and behavioral health of Oklahomans and achieve efficiencies with or without utilizing commercial managed care organizations (MCO); thus, it is our hope that these comments are helpful regardless of the model chosen by the State to pursue value-based care.

Enrollees

1. ***How and when should OHCA transition aged, blind, and disabled (ABD) and other initially excluded individuals to managed care?***

If a managed care system is pursued, the State should focus on the initial Expansion population to ensure implementation of any health care coverage meets their needs, including unforeseen behavioral health needs, before transitioning the ABD population to an MCO. The ABD population would result in even more members with serious mental illness (SMI)/serious emotional disorder (SED) transitioning into the plans. Utilizing the TANF/MAGI and adult Expansion groups to identify issues with SMI/SED behavioral health care delivery will be critical to preventing larger issues later.

We understand that Oklahoma's Expansion population will likely increase Medicaid enrollment by 34 percent (between 178,000 and 233,000 Oklahomans). Of these new enrollees, 78 percent will be adults without children, 64 percent will be individuals in a family with at least one worker, and 73 percent will have incomes below the poverty level ($17,240 for a family of two). The racial and ethnic composition will include 54 percent White, 11 percent Black, 9 percent Hispanic, and 26 percent other races or ethnicities.[7]

Previously uninsured and low-income populations will likely have a significant number of individuals with SMI and SED, and their mental health conditions will not be known at enrollment. Previous attempts to enroll these populations may have failed due of insufficient documentation or follow-through in the application and enrollment process. In addition, the Temporary Assistance for Needy Families/Modified Adjusted Gross Income (TANF/MAGI) populations will also have a number of individuals with SMI and SED who may be unidentifiable in the current Medicaid enrollment data. Thus, the State and the managed care organizations (MCOs) would

[7] Shin, P, & Martin, M. (2020, June 24). *Medicaid expansion: Ten years of unparalleled return on investment, improved outcomes.* Oklahoma Policy Institute. https://okpolicy.org/medicaid-expansion-ten-years-of-unparalleled-return-on-investment-improved-outcomes/

need to be prepared to manage the care for individuals SMI and SED at the implementation of the managed care program.

Nationally, commercial plans experienced challenges managing integrated physical and behavioral health Medicaid benefits. These challenges include: adapting best operational practices for integrating SMI and SED populations, possessing a limited understanding of evidence-based practices necessary to ensure positive outcomes for members and the ability of MCOs to control costs.

There is no evidence of a multi-state evaluation of commercial plans, but there are provider and stakeholder interviews, quality reviews and surveys suggesting inadequate performance resulting in significant challenges for members and providers.[8] These challenges focus on overly aggressive utilization management strategies that do not consider the appropriate length of treatment for evidence-based practices,[9] delayed provider claims payments and poor communications with primary care providers, among other concerns. Even commercial plans with previous experience operating specialty behavioral health MCOs have experienced challenges illustrating the need for close oversight to ensure delivery of adequate, evidence-based care.

To address these concerns, the State should anticipate the experience level MCOs must have during the procurement process and be prepared to oversee the MCOs' implementation of the Expansion population, especially with the inevitable enrollment of SMI and SED populations.

If a managed care program is pursued, the State would need to take extra care to ensure MCOs deliver adequate, evidence-based integrated care to SMI/SED populations with positive outcomes. Our recommendations would include:

- **Build a strong internal team to manage the procurement and oversight of MCOs and develop strong working relationships with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to address these populations.** Tennessee is an example of a state Medicaid program that began with numerous challenges and over the years has built its internal staff competencies to oversee MCOs' operations by focusing on strategies that obtain effective service outcomes and cost controls. ODMHSAS should be deeply involved in addressing oversight of behavioral health care. States that purchase MCO services without effective collaboration with their mental health department, and with limited accountability strategies, have suffered the consequence of poor MCO oversight, resulting in inadequate provider networks, limited use of evidence-based practices that achieve better outcomes, and higher costs for physical health care as well as behavioral health care over the long-term. Kansas is an example of a state where oversight of behavioral health care and the disabled/ elderly

[8] Associated Press. (2020, July 27). *Survey shows Iowa* providers don't like privatized Medicaid. Modern Healthcare. https://www.modernhealthcare.com/medicaid/survey-shows-iowa-providers-dont-privatized-medicaid

[9] July 20, 2020, Interviews and focus groups with Nebraska providers serving the SMI and SUD populations.

population under managed care was delegated to a state agency (KDADS) without building the skill set of that agency. The overall oversight of the MCO program remains with the Medicaid agency. The result is a patchwork of oversight resulting in poor outcomes.[10]

- **Build on the example set by Oklahoma's Health Homes to deliver effective integrated care for the SMI/SED populations through Oklahoma's Health Homes.** OHCA, in collaboration with ODHMSAS, has a solid foundation to further develop Health Homes. Oklahoma was one of the first states to pilot Health Homes. Its Health Home models for children and adults with serious behavioral health conditions provides a strong based to build on. MCOs can contract with the Health Homes to address the Expansion population members with SMI and SED and other children with multi-system involvement (child welfare, juvenile justice, special education).
- **Require the MCOs to include any Certified Community Behavioral Health Clinics (CCBHC) in their networks and to use the payment system developed by the State.** CCBHCs are clinics that have been validated through certification as meeting specific standards and providing comprehensive services, including strong coordination of care that addresses both physical health and behavioral health care services. Similar to federally qualified health centers (FQHCs), CCBHCs have extensive experience engaging and serving low income people with complex health conditions and will help ensure the adequacy of the provider networks to meet the needs of Medicaid members.
- **Require the MCOs to offer contracts to all community mental health centers (CMHCs) and publicly-funded providers of substance use disorder treatment services who are doing business with ODMHSAS to ensure coordination of benefits and continuity of care.** The inclusion of these providers helps ensure engagement of members in services and supports the state's goals of improved health outcomes and cost containment. People may roll on and off of Medicaid eligibility, therefore providing continuity of care will lead to better health outcomes and lower costs to the state.
- **Reduce the administrative burden on providers.** Anticipate the need for some providers to prepare for billing multiple MCOs, rather than the State directly, and require MCOs to coordinate and streamline credentialing and other administrative functions to reduce the administrative burden on providers to participate in multiple networks. (See credentialing recommendation later in this response.)
- **During the procurement, require MCOs to describe their strategies to work with publicly-funded providers.** Specifically, MCOs must assist providers to adapt to their payment mechanisms and reporting methods, including fee-for-service or value-based purchasing. Include this as a scored and weighted item in the application review tool.

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[10] Marso, A. (2016, November 2016). *Report: KanCare delivered on cost, not quality of care.* Kansas Health Institute. https://www.khi.org/news/article/report-kancare-delivered-on-cost-not-quality-of-care
Marso, A. (2018, May 9). Does KanCare work? The state's data is so bad, legislative auditors can't tell. *The Kansas City Star.* https://www.kansascity.com/news/business/health-care/article210730674.html
Associated Press. (2018, May 14). Auditors unable to analyze KanCare data because documentation is so poor. *Lawrence Journal–World.* https://www2.ljworld.com/news/2018/may/14/auditors-unable-analyze-kancare-data-because-docum/

- **Require the MCOs to implement the Collaborative Care Model (CoCM)**[11] **for the Expansion population and other Medicaid members with mild to moderate behavioral health conditions.** The CoCM, an evidenced-based practice for integrated care that embeds behavioral health clinicians and case managers in medical provider practices, allows timely consultations from psychiatrists and employs measurement-based care. This model is effective in providing earlier treatment and good outcomes, circumventing deterioration to more complex behavioral health conditions. As part of the MCO approach to implementing CoCM, require MCOs to describe how it will work with providers to use CoCM billing codes.
- **Phase in the full ABD population over time after success with the TANF/MAGI and Expansion population members with SMI/SED.** The State and the MCOs will have the opportunity to assess the effectiveness of managed care for the Expansion population, including the ABD-like population with SMI and SED. MCOs' goal should be to enhance the current Health Home model and build on their success to scale up working mechanisms for the new, larger ABD population. Thus, MCOs should contract with Health Homes during the initial implementation of managed care.
- **Provide adequate tools to assist providers with effectively integrating and managing care.** Behavioral health care providers have had limited opportunities to develop electronic medical records nationally because of the emphasis on physical health care medical record development. In recent years, there are more behavioral health integrated electronic records with improved functionality. The State and the MCOs should provide resources and incentives to providers to help them update their electronic systems when necessary. Small, independent primary care providers in the Primary Care Case Management Program (PCCM) likely face similar challenges in being able to share information. Access to HIPAA-compliant electronic health records and reporting protocols, and clearly identified policies and procedures to facilitate information sharing and collaborative care, is essential for behavioral health care providers.
- **Phase in the ABD and other initially excluded populations.** The timing of transitioning these populations into managed care could occur in year five of the rollout. The successful transition of the current fee-for-service (FFS) system to a contracted managed care system involves numerous and significant adaptations at the state and local levels, as well as at the MCO level once they are introduced into the Oklahoma Medicaid environment. The state will, of course, need to organize to bring the right expertise into the planning and procurement process, providers will need to tool up for the change, and MCOs will have to develop networks that meet the Medicaid members' needs and otherwise are prepared to do business in Oklahoma.

Assuming a window for such a transition to managed care would require a minimum of one year for procurement and contracting (this includes procuring MCOs, an enrollment broker, and an External Quality Review Organization), another year once contracts are in place (e.g., readiness

[11] AIMS Center. (2020). *Collaborative care.* University of Washington, Psychiatry &Behavioral Sciences Division of Population Health. https://aims.uw.edu/collaborative-care

reviews and implementation and contract approval from CMS, systems testing, provider recruitment, member education and choice periods), and then at least three full years of operation and evaluation of performance, the earliest it is feasible to transition ABD and other special populations is in year five.

2. ***Should the state require each MCO to enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with serious mental illness, or other groups?***

Specialty plans can be a very useful approach, but require careful analysis. Each special population should be evaluated to determine its unique needs, the availability of specialized providers needed in the network, and the actuarial implications of using one or more MCOs to manage the care for the specific population. For example, if the specialty population and the availability of qualified specialty providers is small, it is likely not feasible to spread the risk across multiple plans while maintaining quality care and achieving improved health outcomes. Specialty providers are often not prepared for the administrative burden of managing participation in multiple MCO networks, and their lack of willingness to participate in managed care will be a detriment to members.

Use a specialty plan for foster children. In neighboring states where foster children are enrolled in multiple plans, experiences have not been very good, but Texas and Florida report success with having a single plan for all children in foster care. The legal and policy requirements related to child protective services and family interventions seems to work best when there is one statewide MCO. Thus, we would recommend having one specialty plan for the approximately 8,600 Oklahoma children who are involved in the foster care system. (The specialty plan can serve other populations as well.)

From the start of the managed care program, evaluate MCO performance with the Expansion population that has behavioral health conditions. OCHA and ODMHSAS should indicate in its initial procurement that it intends to evaluate the performance of the MCOs management of the Expansion population with serious behavioral health conditions. (Some members of the Expansion population with serious behavioral health conditions will not be known at the time of enrollment.) The goal is to determine if a specialty MCO would be more effective in achieving the desired outcomes for these populations. It will take at least three full years to evaluate the effectiveness of the MCOs. Arkansas, Arizona and New York have reported good outcomes for their specialty plans that serve people with serious behavioral health conditions after phasing in these programs to integrated managed care.

3. ***How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking and eating healthier***?

Check if adults with serious behavioral health conditions have metabolic syndrome. Using the claims management and care management system information, identify individuals who have metabolic syndrome and offer them education and monitoring tools in collaboration with their

Health Home provider. This would include paying for high-fidelity, evidence-based programs that promote (physical and mental) illness self-management, such as: Wellness Recovery Action Plan, Whole Health Action Management, Enhanced Illness Recovery Management, InShape, Dimensions: Wellbody, NEW-R and other tools developed to promote wellness for people with serious mental illness.[12]

Provide incentives and help CMHCs and CCBHCs to track quality care metrics associated with the delivery of health and wellness services and outcome monitoring, such as:

- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up Plan
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Pay for or provide financial support for gyms and exercise-focused memberships. Ideally, these programs would be integrated with Health Home providers. Alternatively, financially support private/public partnerships between Health Home providers and organizations providing fitness and wellness resources such as the YMCA and local food banks.

Offer incentives and reward providers to engage in care coordination within team-based care models, and care coordination with agencies/partners. Moreover, offer and promote easy communication strategies and tools among CMHCs, CCBHCs, and primary care and specialty physicians, such as use of protected/encrypted email systems and technology solutions that bridge communication between electronic health records.

Provide incentives for continuous health information exchange. This includes information exchange among CMHCs, CCBHCs, FQHCs, hospitals and emergency departments and urgent care providers.

Use and provide incentives for automated communication. These include systems that provide automated texting, emails, and phone calls to remind people of appointments.

Offer member incentives to complete health assessments. These include free blood pressure cuff, scales, discounts for glycemic monitor test strips or other health aids and tools.

[12] University of Illinois at Chicago Center on Mental Health Services Research and Policy. (2020). *Our completed research & evaluation* studies. https://www.center4healthandsdc.org/knowledge-translation-from-our-completed-research.html

Provide incentives for the implementation of member data portals. The member portals should focus on helping members communicate with their providers and monitor their health information.

Provide incentives to providers for engaging members with behavioral health conditions in wellness planning. This includes paying for Wellness Recovery Action Plan facilitation and other tools developed to promote wellness for people with serious mental illness.[13]

Benefits

1. ***What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?***

Establish telecommunications technology to provide quick access to mental health care through telemedicine and telehealth, including care coordination and peer support. In addition to tele-video capacity, use of texting and telephonic applications will ensure the "high-touch" many members need to self-manage their illnesses and follow through with provider recommendations. The telehealth capacity should include access to digital evaluation and management visits and digital telepsychiatry.

Coordinate transportation services that will show up at the designated times and place. This will help individuals with SMI/SED who may not have a caregiver get to multiple appointments consistently, improving treatment engagement.

Expand the behavioral health care provider network for delivery of evidence-based practices to the Expansion population and underserved populations. There is a significant need for additional providers who have the capacity to offer evidenced-based practices such as the Collaborative Care Model (CoCM) and team- and community-based intensive in-home family supports for children, youth, and their families, and rehabilitation services for adults, children, and youth with serious behavioral health conditions.

2. ***What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?***

MCOs must make sure providers and members have incentives to stay engaged and activated to stay healthy, and take preventative measures to avoid chronic disease. Facilitating access to technology for providers and members will be helpful, especially as Oklahomans deal with health issues such as the COVID-19 pandemic.

In response to COVID-19, CareOregon identified high-risk patients by incorporating social health data (race, ethnicity, socioeconomic status, etc.) into their analytics and providing this information to providers. This approach helps providers have a more holistic perspective of their patients' medical needs. The COVID-19 epidemic prompted CareOregon, a Medicaid managed

[13] University of Illinois at Chicago Center on Mental Health Services Research and Policy. (2020).

care plan, to more fully utilize population health data and share this information with providers. CareOregon is a leader in using data to identify and coordinate care for its members with the most complex needs.[14] The data-sharing protocols require special attention, particularly when sharing behavioral health and substance use information, but there are reportedly useful data-sharing strategies available. OCHA could require MCOs to develop a similar population health approach by identifying members with complex health needs and sharing this information with Health Homes.

3. ***How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education, and employment assistance?***

Document referrals to social service agencies and outcomes. Referrals to social service agencies listed in the question should be part of the members' medical records and case management documentation through closed loop referral processes. According to CMS, closing the loop on a referral involves the receiving provider sending a report to the referring provider after completion of the visit that resulted from the referral. This is a long-standing common practice in clinics, with specialists faxing encounter reports to the primary care provider after they see one of the primary care provider's patients.[15]

MCOs could contract with social service agencies to provide value added services. MCOs should communicate the resources available to Health Homes, assuming individuals with complex conditions will have access to Health Homes under the managed care model.[16]

4. ***How could OHCA measure MCO performance on social risk factor mitigation strategies?***

The state and MCOs could use measures already in place in the ODMHSAS provider networks for adults, children and youth.[17] Further, MCOs should provide value-based purchasing initiatives and cost-effective, in-lieu-of services that emphasize outcomes as well as provide incentives to Health Homes that address social risk factor mitigation and improve employment and education. The latter initiatives are especially important for members in the TANF/MAGI[18] and Expansion populations who are experiencing first episode psychosis. Ensuring that MCOs are

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[14] Nuamah, A. (2020, August 6). *How COVID-19 is expanding CareOregon's approach to defining high-risk patients*. Center for Health Care Strategies, Inc. https://www.chcs.org/how-covid-19-is-expanding-careoregons-approach-to-defining-high-risk-patients/?utm_source=CHCS+Email+Updates&utm_campaign=63a58cabcd-Amit+Shah+blog+08%2F06%2F20&utm_medium=email&utm_term=0_bbced451bf-63a58cabcd-157186217

[15] Pierson, B. (2018, July 17). *CMS closed-loop referral: OCHIN ahead of the curve.* OCHIN. https://ochin.org/blog/blog/cms-closed-loop-referral

[16] Nuamah, A. (2020, August 6).

[17] Oklahoma Department of Mental Health and Substance Abuse Services. (n.d.). *Enhanced Tier Payment System (ETPS) — pay for performance.* http://www.odmhsas.org/eda/etps/

[18] U.S. Centers for Medicare & Medicaid Services. (n.d.). *Modified Adjusted Gross Income (MAGI).* https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/#:~:text=Modified%20Adjusted%20Gross%20Income%20%28MAGI%29%20The%20figure%20used,Medicaid%20and%20the%20Children%27s%20Health%20Insurance%20Program%20%28CHIP%29.

familiar with the existing Oklahoma models of care is crucial to the success of the implementation.

5. ***How can MCOs improve access to evidence-based behavioral health care such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication-assisted treatment for opioid use disorder or Assertive Community Treatment?***

OCHA could require MCOs to develop provider networks that can offer all the services in Oklahoma's state Medicaid plan for adults and children. Further, MCOs could provide value-added services and cost-effective services in lieu of more expensive services such as Florida's plans that offer partial hospitalization in lieu of inpatient psychiatric services. The provider network should include organizational providers that have the staffing to offer community-based intensive services, such as intensive in-home, family-based services, Multisystemic Therapy and other rehabilitation services listed in the state plan. These services are typically offered by organizational providers such as CMHCs, CCBHCs and providers of specialty services for children.

MCOs should have a provider network that can offer all state plan services, including those services usually associated with adults and children with serious behavioral health conditions, as experience shows that commercial Medicaid plans frequently conclude many of these services are not part of a health plan benefit for the general Medicaid population. Oklahoma recognizes the importance of providing a full range of evidence-based services through the behavioral health benefits listed in its state Medicaid plan. Many adults, children and youth who have not yet been diagnosed with either an SMI, SED or substance use disorder have mild to moderate behavioral health conditions. These conditions would benefit from early assessment and treatment with evidence-based practices based on their behavioral health functioning at home, school or work. Access to these services earlier than the average decade from onset of mental health conditions to treatment would prevent the deterioration that occurs when anxiety, depression and other conditions are left unattended.[19] While MCOs may not have a lifetime service contract for each member, there are both short-term and long-term savings associated with early treatment of behavioral health conditions, including medical cost offsets. The savings generated from early treatment will positively impact the state's Medicaid program over the long-term. Further, as mentioned previously, the Expansion population will likely include individuals with SMI and SED who will require more intensive services.

Current gaps in services will increase with the Expansion population. Current service capacity of state plan services is limited for all populations, particularly the evidence-based intensive services for children and families. MCOs may have challenges in contracting with a providing network that is able to offer all of these services, and paying adequate rates, especially if the utilization in the capitation rates is low. The Expansion population will add to the demand for these services. OHCA, in collaboration with ODMHSAS, should study current utilization through Medicaid claims data and compare utilization to the prevalence of behavioral health conditions

[19] Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004, February 20). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2):393–415. doi:10.1111/j.1475-6773.2004.00234

in the Medicaid program. OHCA, ODMHSAS, and the MCOs would need to collaborate to determine how to ensure accessibility, given the small FFS provider network, in order to offer the full range of state plan services, which would result in fewer inpatient and emergency department services as more outpatient evidence-based practices become available. Provider recruitment is an important MCO function, but it is equally important to use the public safety net providers that have experience with SMI/SED for specialty behavioral health care services. The State should require MCOs to contract with existing public providers, using a minimum state Medicaid fee schedule based on adequate rates for evidence-based services. MCOs would also need to add providers that fit into local systems of care for children and adults and are responsive to local communities. MCOs must understand local systems and how to enhance rather than disrupt them.

Screening should be available through all provider types, including office-based individual providers, facilities, and organizational providers. This includes SBIRT and early screening for behavioral health conditions such as depression, anxiety, and other conditions in order to provide early identification and treatment. The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening developed by CMS, or another tool such as the well-researched Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE),[20] should also be routinely used.[21] MCOs should be required to develop value-based purchasing initiatives aimed at increasing the penetration of SBIRT, medication-assisted treatment (MAT) and Assertive Community Treatment that have documented cost-effective outcomes.

MCOs should offer all the Early and Periodic Screening, Diagnostic and Treatment services for children and youth. These include children's psychosocial rehabilitation intensive family interventions (IFI) and intensive-in-home support skills training (IHH), and crisis intervention services, including but not limited to mobile team and facility-based crisis stabilization. Early identification, assessment and treatment may prevent the development of more serious behavioral health conditions by offering these services early the child's development.

Similarly, for the adult population, MCOs should also offer all the state Medicaid plans services. For adults who have an SMI and require Programs for Assertive Community Treatment (PACT), early access to that service through an MCO network provider is critical. If the State and the MCO then want to disenroll the individual from the MCO and transfer them to the FFS system, there should be a transition period of at least 60 days while maintaining the same PACT provider for the course of treatment. MCOs can provide access to these services by contracting with the public providers/CCBHCs and other safety net mental health and substance use treatment providers that offer PACT.

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[20] National Association of Community Health Centers, Inc. (2019). *PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences.* https://www.nachc.org/research-and-data/prapare/

[21] Center for Medicare and Medicaid Innovation. (n.d.*). The Accountable Health Communities Health-Related Social Needs Screening Tool*. U.S. Centers for Medicare & Medicaid Services. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

For youth and adults with opioid use disorders (OUD), MCOs should contract with public providers and other licensed opioid treatment programs (outpatient and residential) to provide the full continuum of American Society of Addiction Medicine (ASAM) services, including withdrawal management and induction of MAT in residential settings prior to discharge. To help expand access, MCOs should assist physician practices and health systems by providing information on the federal/state rules and requirements for delivering MAT and offer higher rates to physicians who provide these services. The State should require MCOs to offer MAT for opioid use disorders as the first treatment approach in outpatient or residential treatment, rather than require multiple relapses prior to prescribing MAT.

The State should work closely with ODMHSAS to encourage the number of CCBHCs that by definition will provide a comprehensive array of evidence-based services and supports.

6. ***What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention, and member satisfaction?***

MCOs could contract with the NAVIGATE First Episode Psychosis program (FEP) to provide Coordinated Specialty Care (CSC)[22] for the early treatment of psychosis in young adults. CSC is an evidence-based service that identifies young people in the early stages of psychosis, minimizes barriers to treatment and facilitates successful engagement in treatment while fostering resilience. CSC helps them transition to lower intensity services and supports.[23] With about a third of all people with a first episode psychosis enrolled in Medicaid, it is important for MCOs to offer this service, which has significant benefits because it changes the trajectory of schizophrenia for youth and young adults by helping them manage their conditions. If CSC is not available at the time of the first episode of psychosis, the typical course of illness involves multiple episodes of acute mental illness, with accumulating disability between periods of active psychosis and increases in long-term health care costs.[24]

MCOs can make this service available by contracting with the NAVIGATE programs, using a case rate model that covers the cost of this evidence-based practice. Under managed care, MCOs can

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[22] Gingerich, S. (n.d.). *First episode psychosis and the NAVIGATE treatment model in Oklahoma.* https://oklahoma.gov/odmhsas/documents/fep%20and%20nav%20model-ok.pptx

Mueseer, K. T., Pen, D. T., Addington, J., Brunette, M. F.,Gingerich, S. et al. (2015, July). The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services, 66*(7): 680–690. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400413

https://www.bing.com/search?q=Oklahoma+Navitate+program+for+Fep&cvid=c2a735072a75420b94c7650f97e2d187&pglt=299&FORM=ANSPA1&PC=LCTS

[23] Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2014, April 14). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care.* National Institute of Mental Health.

https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

[24] Meadows Mental Health Policy Institute. (2019, December). *Payment strategies for Coordinated Specialty Care*. www.texasstateofmind.org

develop a case rate that covers the full cost of services and achieve better outcomes for youth and young adults with emerging psychosis. Guidance on how to construct an alternate payment rate for CSC, and coding options, are readily available.[25]

Individual Placement and Support (IPS) is another added-value service that would be useful for individuals with SMI. IPS programs help individuals find jobs that pay competitive wages in integrated settings (i.e., with other people who do not necessarily have disabilities) in the community. The job supports provided by IPS programs vary from person to person, based on need and desire. IPS can be covered by Medicaid because of its focus on rehabilitation skill-building and helping individuals manage their illnesses in the workplace. The procedure code for Supported Employment is H2024 for a per diem rate with the expectation of 12 sessions on average per month. Oklahoma can pursue authority for this service through the 1115 waiver for populations with SMI or substance use disorders.

Wellness Recovery Action Plan (WRAP) facilitation services are effective and highly sought by adults with SMI. WRAP is a manualized group intervention that members can use to develop wellness action plans to self-mange symptoms and illness.[26]

7. ***How can MCOs improve access to transportation for SoonerCare members?***

Often, a common problem for Medicaid members is obtaining timely transportation to appointments, particularly in rural, frontier and densely populated/higher crime areas. It may be useful to have performance contracts that provide incentives for timely responses and transportation in densely populated/higher crime areas. The use of telehealth for services that do not require in-person visits should be routinely offered to people who have difficulty obtaining transportation.

8. ***Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?***

Yes. Other ride-sharing opportunities should be reimbursed through the MCO. Other states have been successful when MCOs are permitted to reimburse the ride-sharing services, as long as protections for members are in place.

Quality and Accountability

1. ***What mechanisms should the state use to incentivize MCOs to improve member outcomes?***

For Medicaid enrollees with behavioral health conditions who receive services from CMHCs and CCBHCs, build on the Oklahoma Enhanced Tiered Payment System developed in 2011 by ODMHSAS in collaboration with the National Association of State Mental Health Directors.[27] This

[25] Meadows Mental Health Policy Institute. (2019, December).

[26] University of Illinois at Chicago Center on Mental Health Services Research and Policy. (2020). *Wellness Recovery Action Plan.* https://www.center4healthandsdc.org/rct-on-wrap.html

[27] Fields, S., & English, K. (2011, December). *The Oklahoma Enhanced Tier Payment System: Leveraging Medicaid to improve mental health provider performance and outcomes*. National Association of State Mental Health Program

is a value-based purchasing approach that can be a foundation for future efforts to incentivize MCOs and their providers. Indicators used by the CMHCs/CCBHC include standard HEDIS measures, which are considered baseline measures for behavioral health care.

2. ***What are the most important indicators of MCO performance? Why?***

Use the standard HEDIS measures because these offer the opportunity to not only compare performance across Oklahoma's MCOs, but also provide information that can be used to compare MCOs' performance nationally. The CCBHC performance measures in use by CCBHCs should also be reviewed to determine final performance measures.

3. ***What measures of health outcomes should be tracked?***

Use the measures developed for the Oklahoma CCBHCs, which meet national standards and provide useful information for OHCA and ODMHSAS.[28]

Care Management and Coordination

1. ***How can utilization management tools work best for members and providers?***

Require MCOs to assign utilization management staff who are knowledgeable about Oklahoma's Medicaid state plan services and array of evidence-based practices. In addition to having standardized behavioral health care utilization guidelines (see below), MCOs should assign utilization/care managers with behavioral health expertise. Care managers should have a specific understanding of Oklahoma's Medicaid state plan services like intensive family interventions and in-home support skills, Programs for Assertive Community Treatment (PACT), Multisystemic Therapy and other evidence-based practices. Staff providing utilization management and continuing care authorizations should be knowledgeable on treatment guidelines for each evidence-based practice.

2. ***How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?***

Use standardized behavioral health care guidelines, including ASAM patient criteria for substance use disorders, and follow length of treatment guidelines for evidence-based practice. For behavioral health care services, the state adopt a standard set of utilization guidelines developed in collaboration with MCOs, providers, ODMHSAS, and OHCA that are based on the service definitions in the state plan. MCOs should not use their own utilization guidelines. All utilization management should comply with requirements that service authorizations must be sufficient in amount, duration and scope to reasonably achieve its purposes.[29] For individuals with SMI/SED, that might mean initial authorizations for three months for Multisystemic Therapy services for children and six-month authorization periods for adult

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Directors.
http://www.odmhsas.org/eda/etps/The%20Oklahoma%20Enhanced%20Tier%20Payment%20System%20Final.pdf

[28] A list of the CCBHC quality measures (the first nine are measures at the behavioral health center level and the last 13 are measures at the state level) can be found at this link:
.https://www.ok.gov/odmhsas/documents/CCBHC%20quality%20measures.pdf

[29] Utilization management must be consistent with §§440.230.

members using PACT. Utilization review should focus on making sure Multisystemic Therapy meets medical necessity requirements at initial authorization. Authorization time periods should ensure the initial course of treatment is adequate (e.g., 30 days), with further reauthorization time periods being of sufficient duration that the term of expected treatment could be accomplished, (e.g., 30 days) , unless the youth uses more emergency and inpatient care, which would suggest a different level of care may be needed.

MCO contract language should require the use of utilization management procedures that emphasize person- and family-centered, individualized services and address mental health parity. MCOs should not employ cost saving measures that are independent of the individual member's needs. Mental health parity should be integral to all utilization management processes.

3. ***What specific network development, care delivery, and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?***

Contract with behavioral health care specialty providers. MCOs should be required to contract with the following behavioral health care specialty providers:

- Community mental health centers currently under contract with ODMHSAS,
- Certified Community Behavioral Health Clinics,
- FQHCs and rural health clinics,
- Clinics that serve American/Indians/Alaska Natives,
- Oklahoma Systems of Care providers, and
- All licensed school-based mental health clinics within the MCO's service area.

4. ***How can MCOs improve the management and coordination for members with chronic or complex health conditions?***

MCOs should design and support information sharing among the Health Homes and other providers. Care delivery and coordination are best done in collaboration with comprehensive providers like CCBHCs. However, providers do not have access to all claims, prescriptions and other information to coordinate care for members across physical and behavioral health care services. By sharing information, MCOs can inform care coordination plans and work with physical and behavioral health providers and members to develop and implement plans. MCOs should be required to create and lead such collaborations for high-need members.

The State should conduct readiness reviews and ongoing monitoring of MCOs, which would include management of members with complex health conditions. The State should monitor and assess MCOs' performance of collecting and sharing physical and behavioral health data and its availability to providers serving members with complex needs and comorbid conditions as part of readiness reviews.

5. ***What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice, and others whose needs present unique considerations?***

MCOs should be required to designate staff to work with existing initiatives in place in the communities that target these populations. For the justice-involved population, the designated staff should demonstrate knowledge of the Sequential Intercept Model,[30] use of Oklahoma's evidence-based screening and assessment tools[31] and participate in state and community-based coalitions focused on providing behavioral health care services to justice-involved members. Arizona's Complete Care RFP for integrated care provides relevant information on staffing and outreach regarding other populations of interest.[32]

Member Services

1. ***What metrics should be used to measure MCO performance with regards to member services?***

- Telephone abandonment rates from first ring;
- Telephone hold rates from first ring;
- Number of languages for which oral interpretation was available compared to number of languages requested for oral transportation;
- Number of languages with written translation documents compared to the number of prevalent languages in the MCO service area;
- Number of requests for auxiliary aids and disposition;
- Number of grievances logged by category of grievance (e.g., provider rudeness, quality of care, no access to translation, appointment wait times) and referred the appropriate party for resolution;
- Number and type of inquiries and disposition by category (e.g., grievance, appeal, referral information); and
- Number of individuals using suicidal language or expressing intent and disposition, by category (transferred to crisis line, transferred to licensed clinician, etc.).

2. ***How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?***

Provide information and customer service in languages other than English that are most often spoken by ethnic groups in the state. For example, the Spanish language may be different for populations from Puerto Rico, Mexico or Central America. Look at both current and future demographics to anticipate growth in new immigrant groups.

Ensure that all information is written at a 6th to 8th grade reading level.

[30] University of Illinois at Chicago Center on Mental Health Services Research and Policy. (2020). *Sequential Intercept Model: Jail diversion and alternative justice interventions.* https://www.center4healthandsdc.org/sequential-intercept-model.html

[31] Oklahoma Department of Mental Health and Substance Abuse Services. (2020, February 7). *Offender screening page.* https://www.ok.gov/odmhsas/Substance_Abuse/Criminal_Justice_Services_/Offender_Screening.html

[32] Arizona Cost Containment System. https://www.azahcccs.gov/PlansProviders/HealthPlans/YH19-0001.html

Use culturally relevant language in messaging. For many non-European ethnic groups and recent immigrants, messaging aimed at self-care may not be effective and should instead be focused on taking better care of oneself as a way to take care of family. Messages to stop smoking, eat better or get in to see your primary care provider such as, "Do it for your grandkids," may be more effective than, "You owe it to yourself."

3. ***How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?***

Use simple and engaging apps that work really well from phones, with "buttons" to push rather than fields to fill in.

4. **How can MCOs best communicate with members who do not have a mobile phone, computer, or reliable internet service?**

MCOs can finance low-cost technology to members as part of a wellness plan for those members who do not have access to reliable communications. For example, Grand Lake CCBHC successfully used technology to create better access to care and reduced expensive use of psychiatric inpatient care. Also, use surveys by text, email, phone, and community outreach—send out community health workers with surveys on tablets to flea markets, farmer's markets, Walmart, and other similar places in local communities.

5. ***How can MCOs communicate with members and receive regular input and feedback on program improvements?***

For members with SMI and SED, identify self-help peer support networks and family support networks to do focus groups on access and quality issues.

6. ***What tools and resources would help members search for providers? What information should be provided?***

Using web-based and mobile apps with current information would be a benefit to members. Many times, provider directories are out of date and difficult to use.
Provide easy-to-use search engines, apps and a mailings alerting them to these tools.

Provider Payments and Services

1. ***What metrics should be used to measure MCO performance with regards to provider services?***

For individuals with behavioral health conditions, use the HEDIS measures plus additional measures, building on the existing reporting infrastructure installed by ODMHSAS.

2. ***Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?***

For behavioral health care services, the State should indicate that the payment for behavioral health care services should be no less than the current FFS rates and ODMHSAS funding. Providers and stakeholders currently report that the current rates do not cover the delivery of

evidence-based practices. The State should encourage the use of case rates and other alternative payment methods.

The State must be prepared to continually assess network adequacy and determine if rates are preventing providers from meeting the mental health and substance use treatment needs of members. The State could regularly survey MCO network providers, professional associations, and other stakeholders to identify reimbursement challenges.

An upcoming challenge is the potential impact of managed care on the Supplemental Hospital Offset Payment Program (SHOPP) program.[33] The State will have to address the pending requirements of the new Medicaid Fiscal Accountability Regulations (MFAR),[34] which are forthcoming within 60-90 days. If these regulations eliminate SHOPP payments in FFS (which is a distinct possibility), then the state must work with providers to develop a workable, federally-approvable solution to help hospitals. The introduction of managed care may or may not help the situation.

3. What is appropriate for timely payment of claims?

Provider claims should be paid within a maximum of 30 days. MCOs should track and trend provider claims disputes by type of service and their disposition, and provide a report to the State quarterly.

The State should reward MCOs with claims systems that produce rapid payments to providers and track provider satisfaction with claims payment.

4. What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

Use a single Credentialing Verification Organization (CVO). The State should consider requiring the use of a single CVO across Medicaid MCOs to minimize the burden of duplicative credentialing requirements for physicians and other health care providers. Many MCOs already have a credentialing unit or subcontract out this function, a standard approach facilitates provider engagement and promotes more robust provider networks. All Medicaid provider types would use the CVO.

OHCA should monitor the timeliness of provider credentialing. The State should track the length of time the MCOs take to complete provider credentialing and require rapid cycle improvement processes to address problem areas. If the State requires the use of a CVO, there are additional steps to the credentialing process that the MCO must perform, including review of all credentials by a physician-led committee.

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[33] Oklahoma Health Care Authority. (n.d.). *SHOPP hospitals.* http://www.okhca.org/providers.aspx?id=13568

[34] Rudowitz, R. (2020, January 27*). What you need to know about the Medicaid Fiscal Accountability Rule (MFAR*). Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/what-you-need-to-know-about-the-medicaid-fiscal-accountability-rule-mfar/

Current gaps in services are barriers and these gaps will increase with the Expansion population. OHCA and ODMHSAS should study current service use through Medicaid claims data, comparing use to prevalence of behavioral health conditions in the Medicaid program. OHCA, ODMHSAS and the MCOs will need to collaborate to determine how to improve service accessibility in order to offer the full range of state plan services. If additional outpatient evidence-based services were available, the demand for inpatient and emergency department services could decrease significantly.

Current provider and service capacity of state plan services is limited for all populations, particularly the evidence-based intensive services for children and families. MCOs may have challenges in contracting providing networks with all necessary services, and paying adequate rates, especially if the utilization in the capitation rates are low. The Expansion population will add to the demand for these services.

Provider recruitment is an important MCO function, and it is equally important to use the public safety net providers that have experience with SMI/SED for specialty behavioral health care services for the Expansion population. The State should require MCOs to contract with existing public providers, using a minimum state Medicaid fee schedule based on adequate rates for evidence-based services. MCOs must also add providers that fit into local systems of care for children and adults and are responsive to local communities. MCOs must understand local systems and how to enhance rather than disrupt them.

7. ***How can MCOs best communicate to providers about updates and changes to plan policies?***

Notify providers of updates and changes to policies using regular dated and numbered electronic provider bulletins, and posting notification of changes on the MCO and State websites. If the change or update requires substantial modification of workflows or other operations, the State and the MCOs should identify staff to support implementation through technical assistance, and allow a reasonable implementation period for changes that require modifications to information systems or other technology.

8. ***How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues?***

The staffing of the MCO should include a Provider Claims Educator(s), located in Oklahoma, who facilitate(s) the exchange of information between the grievances, claims processing/disputes, and provider relations systems staff to resolve disputes and:

- Educate contracted and non-contracted providers (professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and electronic fund transfer;
- Educate contracted and non-contracted providers on available contractor resources such as provider manuals, website, fee schedules, etc.;

- Interface with the contractor's call center to compile, analyze, and disseminate information from provider calls;
- Regularly review MCO reports on grievance and appeals trends and guide the development and implementation of strategies to improve provider satisfaction; and
- Frequently communicate with providers, including conducting on-site visits, to ensure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

For new providers to Medicaid and especially for peer- or family-run services, MCOs should offer technical assistance on Medicaid reporting and billing requirements, such as training on HIPPA, billing and coding, revenue cycle management and other provider contract requirements. Peer- or family-led organizations often need technical assistance to develop an early warning system set of indicators for monitoring financial viability. Family- and peer-run services throughout the nation have struggled with Medicaid productivity levels that are too high for the service model and staffing capacity. The Medicaid rates for these services should not require more than 50 percent productivity for each peer or family specialist to allow for training, orientation, supervision, and ongoing development of peer and family support services consistent with evidence-based interventions.

For MCOs that subcontract with a specialty behavioral health MCO to manage behavioral health care, provide a claims processing strategy that allows providers to submit the claims to the master MCO. This MCO can either forward the behavioral health care claims to the behavioral health MCO for payment or pay the claim directly. Providers should not have to submit claims to multiple MCOs.

9. ***Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?***

MCOs should have an adequate provider relations staff that regularly communicates with providers to help them understand operational procedures. The provider relations administrator should receive a set of standardized monthly reports that inform the development of provider education strategies. Reports should provide summary information on provider quality, grievances, appeals and claims processing/disputes.

MCOs, in collaboration with the State, should provide transparent information on provider Medicaid enrollment and the MCO credentialing process. Special attention should be paid to helping providers understand the scope of Medicaid state plan services, particularly those for children listed under the Early and Periodic Screening, Diagnostic and Treatment section Attachment 3.1-A, 4.b, and contracting with providers that can offer these services as well as evidence-based practices.

MCOs, in collaboration with the State, should also provide transparent information on member Medicaid enrollment to facilitate enrollment in Medicaid when a provider has initial contact with a person who is potentially eligible for Medicaid.

10. What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

Reinvest a percentage of MCO/provider savings into services. Past Pennsylvania and Iowa behavioral health care carve-outs successfully used models where savings generated through achieving good outcomes for behavioral health care services were reinvested into additional services. These additional services addressed social determinants of health through supportive housing, supported employment and social support agencies to assist with food security and other basic needs. Shared savings models that allow for reinvestment has worked well in managed care programs and improved provider trust.

***11.* How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?**

Implement the Collaborative Care Model in all MCOs. For behavioral health, technical assistance on the implementation and delivery of the Collaborative Care Model (CoCM) is vital. CoCM, an evidence-based integrated treatment practice, is an important strategy for primary care providers in helping adult patients with the treatment of mild to moderate behavioral health conditions. CoCM relies on trained primary care providers and embedded behavioral health professionals who provide evidence-based treatments, supported by regular psychiatric case consultation and treatment adjustment for patients not progressing as expected. MCOs and providers can assist with implementation of CoCM by utilizing the resource material available, at no cost, through the University of Washington's Aims Center.[35] Coding and billing guidance, including separate guidance for FQHCs and rural clinics, are available at the AIMS Center.[36,37]

Implement Child Psychiatry Access Programs for children and youth throughout Oklahoma. The best strategy to assist pediatricians and family medicine physicians is providing ready access to consultation from child psychiatrists and behavioral health clinicians who can provide follow-up specialty behavioral health care when needed. The shortage of child psychiatrists nationally has prompted states to implement Child Psychiatry Access Programs (CPAP) based on the work of the Massachusetts Child Psychiatry Access Project, which, in 2004, established regional behavioral health consultation hubs, each with a child psychiatrist, a licensed therapist, and a care coordinator. Each hub operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers. It supports over 95 percent of the pediatric

[35] AIMS Center. (2020). *Collaborative care.* University of Washington, Psychiatry &Behavioral Sciences Division of Population Health. https://aims.uw.edu/collaborative-care

[36] AIMS Center. (2020, March). *Basic coding for integrated behavioral health care.* University of Washington, Psychiatry &Behavioral Sciences Division of Population Health. https://aims.uw.edu/sites/default/files/Basic%20Coding%20for%20Integrated%20BH%202020_March.pdf

[37] AIMS Center. (2020, April 10). *Summary sheet on payments for behavioral health integration services in federally qualified health centers and rural health clinics.* University of Washington, Psychiatry &Behavioral Sciences Division of Population Health. http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-summary-sheet-fqhcs-and-rhcs

primary care providers in Massachusetts. Other states have implemented similar models attuned to the state's resources and needs.

Texas law established the Texas Child Mental Health Care Consortium (TCMHCC), which in turn, developed the Child Psychiatry Access Network (CPAN), a collaboration of all 13 of the state's public health-related institutions. CPAN supports primary care providers who provide services to children and youth with mental health issues throughout each center's geographic region.[38] After a simple enrollment process, providers are connected with a psychiatric consultant within 30 minutes. A statewide data management system measures need, evaluates responsiveness and improves services and outcomes. Additionally, TCMHCC is working to provide telemedicine support to schools, expand the behavioral workforce in Texas, and fund research projects.

The Partnership Access Line (PAL), offers another leading model of integrating behavioral health care into primary care for children and youth. PAL is a telephone-based mental health consultation system available to primary care physicians, nurse practitioners, and physician assistants. PAL can assist with identifying local resources, assessment locations based on insurance provider and can provide telemedicine appointments. Primary care providers reported that in 87 percent of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements experienced a 132 percent increase in outpatient mental health visits after the consultation call. Surveyed primary care providers reported "uniformly positive satisfaction" with PAL.[39] Following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half.[40]

Network Adequacy

1. ***How should MCOs work with providers to ensure timely access to care standards are met?***

Suggested language for telehealth and telemedicine*:* MCOs should promote the use of telemedicine to support timely access to an adequate provider network. Telemedicine should not replace provider choice or member preference for in person services. MCOs should be responsible for the oversight, administration and implementation of telemedicine services and ensure telehealth and telemonitoring comply with state and federal laws as well as contract requirements and all incorporated references. MCOs should ensure telemedicine is available and used, when appropriate, to ensure geographic accessibility of services to members. In addition, MCOs should be responsible for developing and expanding the use and availability of telemedicine services, when indicated and appropriate. Telemedicine should include the delivery

[38] Texas Child Mental Health Care Consortium, Child Psychiatry Access Network and Telemedicine and Telehealth Programs, § 113.0151 (2019).
https://texas.public.law/statutes/tex._health_and_safety_code_section_113.0151

[39] Hilt, R. J., Romaire, M. A., McDonell, M. G., Sears, J. M., Krupski, A., Thompson, J. N., & Trupin, E. W. (2013, February). The partnership access line evaluating a child psychiatry consult program in Washington State. *JAMA Pediatrics*, *167*(2), 162–168.

[40] Barclay, R. P., Penfold, R. B., Sullivan, D., Boydston, L., Wignall, J., & Hilt, R. J. (2017, April). Decrease in statewide antipsychotic prescribing after implementation of child and adolescent psychiatry consultation services. *Health Services Research*, *52*(2), 561–578.

of diagnostic, consultation and treatment services that occur in person on a real-time basis through interactive audio, video, and data communications, as well as the transfer of medical data on a store and forward basis for consultation. Telemedicine services may be offered by telemedicine organizations located in the U.S. that have a contractual arrangement with the MCO or a local provider licensed by the state of Oklahoma.

Provider payments for behavioral health in-person and telehealth services should be equivalent. The federal guidance for Medicaid and Medicare indicates that telehealth services during the COVID-19 pandemic should be paid for at the same rate as face-to-face services.

A robust array of telehealth behavioral health care services beyond hotlines and internet apps for general wellness should be available through the MCOs. Telehealth should cover virtual visits for members to support continuity in connecting with their established clinician or remain connected to ongoing therapy.

MCOs should offer easily accessible, transparent, and detailed information about telehealth behavioral health care services, clearly identifying the services that will be covered.
All licensed and certified behavioral health care providers, and other qualified behavioral health personnel defined by state rules, should be allowed to provide telehealth services. This permission should include psychologists, psychiatric and mental health nurse practitioners, social workers, licensed marriage and family therapists, licensed professional counselors, certified or licensed alcohol and drug counselors, certified peer support specialists, occupational therapists and other qualified mental health personnel defined by state rules such as case managers. Telehealth services offered by providers who are not licensed for independent practice can be provided under the supervision of a licensed professional in a hospital or provider organization that is licensed or approved by the state, such as Certified Community Behavioral Health Centers, FQHCs, Indian Health Centers and rural health clinics.

2. What are reasonable time and distance standards in Oklahoma by provider type?

Behavioral Health. Industry standards typically include: 1 hour for emergency care, 24 hours for urgent care and 14 days for routine care. For behavioral health care, 60 days for scheduling a routine appointment is too long. Individuals discharged from psychiatric inpatient care should have access to an outpatient provider for follow-up care within 7 days. Behavioral health care telehealth appointments and same-day access should be available to ensure timely access to care. **The MCOs must assist providers to meet these standards by increasing provider capacity and offering support for evidence based strategies, such as telehealth appointments.**

For Psychotropic Medications. MCOs should provide appointments, immediately if clinically indicated, to ensure members do not run out of necessary medications nor decline in behavioral health condition, even prior to starting medications. Consider operating medication groups for members where there is a shortage of psychiatric prescribers, and same-day access to prescribers through telehealth.

3. **How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?**

Pay adequate rates that cover the cost of delivering evidence-based practices. At first glance, some intensive services are more costly than regular treatment-as-usual outpatient care. However, there is an abundance of research that supports the cost effectiveness of evidenced-based care.[41] Timely provision of intensive-family based interventions for children and youth have good outcomes that reduced the use of emergency departments, other crisis services and residential treatment and inpatient care. These services also produce cost offsets to the state for juvenile justice, child welfare agencies and school districts. However, services will not achieve the desired outcomes if the financing does not support the staffing model, training and ongoing supervision and fidelity monitoring. The same advice applies to adult behavioral health care services.

Address the high cost of graduate and other training for physicians, psychiatrists, and other health care and behavioral health care specialists and underrepresented minority students and graduates who have high debts. The educational costs associated with health professions leaves many professionals with high debts. For students and graduates who are willing to work in the public sector, strategies such as loan forgiveness or lower tuition in state colleges and universities is likely to boost the behavioral health care workforce, resulting in increased access to care for the Medicaid populations.
Work with local universities and community colleges to provide training programs for family and peer support specialists that addresses certification requirements.

4. **How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?**

As previously mentioned, implement Child Psychiatry Access Programs statewide. See "Member Services," point eleven's second bullet point.

Grievances and Appeals

1. ***How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?***

Require the MCOs to report on the following items:
Provide a monthly accounting of member grievances by type, timeliness of resolution, and disposition.

Provide a monthly accounting of members and provider appeals of care by level of service, number of denials, timeliness of resolution, and disposition, including the Fair Hearing process.

[41] Substance Abuse and Mental Health Services Administration. (2019, July 19*). Finding evidence-based programs and practices.* https://www.samhsa.gov/sites/default/files/20190719-samhsa-finding_evidence-based-programs-practices.pdf

Require the MCO to assign resolution, tracking and trending quality of care grievances and appeals to the MCOs quality improvement (QI) department and have reports reviewed by the QI committee. Behavioral health grievances and appeal data should be reviewed by quality improvement staff with expertise in behavioral health conditions and services.

Establish a member advisory committee that is representative (whenever possible) of individuals and/or families that utilize all levels of care. The MCO's quality improvement staff should present unidentified data summarizing the types of grievances and appeals, timeliness of resolution, and disposition and invite feedback on strategies to mitigate challenges. To create fidelity, at least 51 percent of the members should have received some level of care through the MCO provider network. At least two individuals with behavioral health conditions should be represented on the committee. The State should review the meeting minutes and compare the discussion and recommendations to the MCO's reports on grievances and appeals.

2. ***How can the state and MCOs use appeals data to improve utilization management and access?***

OHCA and the MCOs should track and trend appeals data by level of care, timeliness of review, and reason for denials. Within the MCO, a physician-led utilization management committee should review all appeals data, by level of care, to identify gaps in services and review the reasons for denials to identify administrative and service delivery challenges (e.g., appeal denied for inadequate information offered by the provider; lack of inpatient bed availability; does not meet utilization criteria, but needs a different level of service that does not exist in Oklahoma). For behavioral health and other specialty services, physician advisors in the specialty, like psychiatrists should participate on the utilization management committee.

Administrative Requirements

1. ***How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?***

MCOs should be required to share data for high-quality coordination of care, particularly for people with complex needs and populations with comorbid physical health and behavioral health conditions, including key demographic, clinical information, and prescriptions. Some MCOs have electronic systems for data sharing among providers with policies in place that provide guidance on data sharing like universal release of information forms[42] that members sign with providers. Data sharing practices must align with the most recent rules related to mental health and substance use information confidentiality.

2. ***What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?***

[42] https://www.northfloridamedicalcenters.org/wp-content/uploads/2016/03/Full-Medical-Record-Release-Form.pdf

High variability in provider information systems and capacity to share information is a significant barrier. The burden for information sharing cannot fall largely on providers without the MCO providing them with necessary resources. Provider payment arrangements that combine flexibility with accountability allow providers to build capacity to manage data sharing and use data for the benefit of the members they serve.

3. ***How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?***

Strengthen the program integrity capacity of OHCA and emphasize the need for strong program integrity initiatives in the MCOs and provider network. The State will need a strong internal program integrity plan and staff to oversee fraud prevention and detection. Experienced MCOs will come with procedures and methods for identifying fraud. The State has existing procedures and should collaborate with MCOs to detect and address fraud. MCOs typically have program integrity functions that can flag potential fraud throughout their operations such as analysis of service utilization trends and outliers, credentialing providers, enrolling members, implementing claims review and quality assurance functions, conducting site visits to network providers, and reviewing medical records. The availability of integrated databases and advanced claims analytics can assist the State with identifying claims and provider outliers that flag further analysis. These strategies can help OHCA and the MCOs detect and prevent fraudulent claims. Providers should also have robust program integrity plans and conduct quality assurance of claims and medical records, to make sure the services provided are covered by Medicaid and match the diagnosis, clinical condition and meet medical necessity.

4. ***Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?***

It might make sense to encourage and give extra credit to MCOs that are on the Marketplace or would be willing to be on it. When it comes to the ABD and other special populations, MCOs that specialize in serving these populations may not have product lines that fit the exchange, and these populations may not be likely to change eligibility and, therefore, need the Marketplace. If a high-quality plan applies and scores well but does not want to be on the Marketplace, it would not necessarily make sense to exclude them, particularly if they can do a good job with the ABD and other special populations.

The stated goals of pursuing a managed care approach are to:

Improve health outcomes for Oklahomans

Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume

Improve member satisfaction

Contain costs through better coordinating services

Increase cost predictability to the state

The questions below are grouped according to the objectives OHCA is seeking to achieve.

Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid

- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting
- MCOs will serve members across the state

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care? **As soon as possible if added benefits are given as it appears the MCO's will provide increased benefits that could improve the health of these vulnerable populations.**
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups? **All MCO's should be required to enroll every population for fairness and consistency.**
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? **By partnering with Community Health Centers, as we are already providing these services. Utilize telehealth and other technology to keep patients engaged.**

Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers
- Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care? **Again, encouraging members to use Community Health Centers. There are 100+ CHC delivery sites in Oklahoma, many within a 30-mile radius or less of all residents in the state. CHC's are in the business of providing access to care for all, and most have same-day appointment availability for physical and behavioral health.**
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing? **The Health Information Exchange (MyHealth) could be a great data sharing tool.**
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies? **Again, I believe MyHealth could greatly assist with this.**
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment? **Several CHC's perform SBIRT and have MAT programs already in place.**
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction? **Registered Dietitians, Diabetes Educators, Lifestyle Coaching, etc.**
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? **Yes! The more options and availability the better.**

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as **state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**
- MCOs will **reimburse providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions
- **OHCA is investigating the use of incentive measures, quality pools and other programs;** MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes? **Data sharing so members can see which MCO's perform the best.**
- What are the most important indicators of MCO performance? Why? **Improvements in CMS Quality measures (diabetes, hypertension, immunizations, cancer screenings, etc.).**
- What measures of health outcomes should be tracked? **The measures should follow the guidelines set forth by CMS. All are important.**

Care Management and Coordination

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- **Conduct health screenings** to identify ongoing need, current providers, and social determinants of health
- **Develop care plans** for identified enrollees and **establish care management and care coordination** based on identified risk and particular health conditions
- **Design health management programs** with a holistic approach to member health
- **Conduct health education** in priority areas and on emerging issues

In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers? **This should be a partnership where the MCO and the provider work together to share data and monitor services.**
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden? **The use of MyHealth could assist with this as it could easily monitor all services.**
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs? **Telehealth is a great delivery tool for behavioral health services. Make those providers already offering integrated behavioral health (and other services), preferred providers.**
- How can MCOs improve the management and coordination for members with chronic or complex health conditions? **Team based approach with Care Coordinators working with those patients (Telligen, Sooner HAN, etc.).**
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations? **Case management services and a preferred network of providers that are capable of meeting the needs of these special populations.**

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- **Answer member questions timely** via telephone or email and resolve grievances and appeals timely
- **Frequently update provider directories** online to help members locate health care providers

- **Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services? **Patient and provider satisfaction surveys with results posted for patients, providers and the OHCA to see.**
- How can MCOs best serve individuals who primarily speak a non-English language? **We use a service called Language Line that offers certified telephonic healthcare translation services for providers and patients.** Individuals who may not understand health care terminology? **Case managers and Patient Care Coordinators could assist with this.**
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs? **CareMessage (HIPAA compliant texting platform), MyHealth, telehealth, patient portals, etc.**
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service? **This is where case managers that can call land line phones would be helpful. If they have no phone at all, possibly assist them in getting one.**
- How can MCOs communicate with members and receive regular input and feedback on program improvements? **Annual in-depth patient satisfaction surveys and shoter quarterly options for feedback.**
- What tools and resources would help members search for providers? What information should be provided? **A user-friendly website with each participating provider, their contact information, and an overview of services offered, along with links to the providers' website.**

Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services? **CMS eCQM's, UDS, HEDIS, etc.**
- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation? **I believe in Value Based Pay, so possibly a small Per Member Per Month, but the majority pf payment should be based on quality improvements. If the providers are keeping the patients healthy, or improving health, expenditures for emergency, specialty and hospital care should decrease; therefore, compensation should be sustainable.**
- What is appropriate for timely payment of claims? **Monthly, by the 15th, for previous month.**
- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed? **Quality measures, panel size, payment methodology, provider and patient portals, etc. Work with MCO's that are willing to offer some standardization and work together to find common ground based on the state's, providers', and patients' needs.**
- How can MCOs best communicate to providers about updates and changes to plan policies? **Email, Newsletters, Alerts on portal, etc.**
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers? **Thorough initial training, a great customer service help desk, FAQs on the Portal, etc. Ongoing frequent training, networking opportunities amongst providers with best practices, etc.**
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes? **Preferred providers could be those that are already participating in ACOs as they are already familiar with this. As providers move towards Value Based Pay, they can become preferred providers.**
- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful? **Added case management for high risk patients, additional education for patients that are struggling with their healthcare goals, evidenced based guidelines for lifestyle change to improve health, etc.**

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

- Examples of industry standards include:

- Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
- Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
- Require all Primary Care Providers have at least some same-day acute care appointments
- Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)

- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met? **It is my belief that same day appointments should be available for most patients, at least via telehealth. They should at a minimum be able to be seen within 2 business days. We use simplified scheduling for our DPI (Dramatic Performance Improvement) model and it has increased accessibility immensely.**
- What are reasonable time and distance standards in Oklahoma by provider type? **See above for timeliness, but there are Community Health Centers (FQHCs) within a 30-minute drive of most Oklahomans.**
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? **Fair payment should entice more providers to participate. Those that are not interested in participating in value based payment likely are not providing the best care and should not be considered.**
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers? **Ongoing training on best practices to support value based pay, evidence based guidelines, standards of care, etc. Also, networking with like-providers would be beneficial.**

Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored? **Transparency and patient satisfaction results should be made available for all members and providers. A qualified customer service help desk to assist providers and patients during business hours would be helpful. Asking random members and providers for their feedback on a regular basis can bring to light any common concerns.**
- How can the state and MCOs use appeals data to improve utilization management and access? **Common concerns should be reviewed and corrected. Reports that reflect utilization and access should be reviewed regularly.**

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- **Gain accreditation** by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- **Maintain an Oklahoma presence,** including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- **Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care? **Utilization of MyHealth HIE is a great way to share data.**
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? **I believe ALL healthcare providers should use the HIE to improve quality and lower costs.**
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed? **Monitoring of claims and anomalies should be done regularly. Timely replies of the providers in question should be mandatory and corrective action plans should be out in place. If the fraud is egregious, paybacks and OIG should be involved.**
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? **That would be a great way to get even more Oklahomans insured, so yes!**

OKLAHOMA STATE MEDICAL ASSOCIATION

August 20, 2020

Oklahoma Secretary of Health Kevin Corbett, CEO
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Dear Secretary Corbett:

Currently, the Oklahoma Health Care Authority (OHCA) is establishing requirements and pursuing stakeholder input prior to finalizing a Request for Proposal (RFP) to seek qualified managed care organizations (MCOs) designed to improve health outcomes, increase access to care, and increase system accountability in Oklahoma's Medicaid program (SoonerCare). The Oklahoma State Medical Association (OSMA) appreciates the opportunity to provide input into this process.

While the RFP is currently in development, the planned release is soon anticipated with an expected implementation date of October 1, 2021. The OSMA truly appreciates the OHCA taking guided steps to assure any structure under consideration is as effective as possible. Your request for information attempts to address several issues including:

- Accreditation Requirement
- Plan Operations in Oklahoma
- State Health Information Exchange Participation
- Primary Care Provider Requirements
- Behavioral Health Specialist Coverage
- Inclusion of FQHCs and Rural Health Clinics
- Timely Credentialing
- Maintaining/Expanding Telehealth
- Providing Health Screening, Health Care, Health Education and Coordination of Care

These are all laudable goals in formulating OHCA's MCO request for proposal. The OSMA would like to assure that when considering a managed care structure for SoonerCare, several additional factors must remain under consideration.

In the 1990s, Oklahoma already tried this approach. The state implemented a managed care model and the results were disastrous. ***A managed care approach institutes an access to care crisis for an Oklahoma population that already faces a serious shortage of health care providers while combating a world-wide pandemic.*** The bureaucratic red tape and delayed payments that are a reality of managed care forced many state physicians to stop taking Medicaid patients. Regardless of the intent to curb costs while expanding services, the fact remains that the number of physicians willing to serve the Medicaid population will decline, especially in rural areas of the state.

As with the previous attempt to incorporate managed care, rural citizens will be forced to drive hours into Oklahoma City or Tulsa just to see a doctor, even if they are lucky enough to find one who was accepting new patients. The state was ultimately forced to scrap the managed care approach to bring physicians and other health care providers back into SoonerCare which currently provides services to 25% of all Oklahomans.

In addition, while the State of Oklahoma is implementing SQ 802 (Medicaid Expansion under ACA), the number of Oklahomans served by SoonerCare will increase by 200,000. A reduction in access to quality health care services through a combination of additional regulatory burdens and a reduction of plan reimbursement rates could not come at a worse time. If the state does not implement managed care correctly, it could result in a catastrophic loss of providers for Oklahoma's most vulnerable citizens and the newly enrolled Medicaid participants.

Some may ask, "Are there savings to be had in the Medicaid system?" Of course, there are. As with any public *or* private entity administering hundreds of millions of dollars, there will always be areas in which monies can be spent more efficiently. That will be the case regardless of structure. However, forcing existing providers out and rationing care to Oklahoma's most needy citizens is not the way to improve health outcomes.

If we want to maintain an adequate provider network for Oklahoma's Medicaid population, any managed care proposal must, at minimum, include the following:

- **Adequate reimbursement:** Over the past several years including under Governor Stitt's leadership, Oklahoma has slowly increased provider reimbursement rates up to 93% of Medicare rates with a goal of achieving 100%. We are realizing a more balanced health care system and have been successful in placing additional physicians in rural Oklahoma. We cannot afford to impede that progress.
- **Prompt payment:** Many of Oklahoma's rural physicians are small employers working as sole practitioners or in a small office. Like any small business, they rely on steady cashflow in order to keep their doors open. At present, OHCA does a very good job at processing and paying claims quickly—far more quickly than most private insurers. Many of these small practice physicians depend on the steady and reliable payment stream from OHCA to pay staff and keep the lights on while waiting for reimbursement from other insurers. Any managed care contract must ensure that this prompt payment continues.
- **Local dispute resolution:** Any out-of-state managed care organization that contracts with OHCA must agree to be regulated and overseen by the Oklahoma Insurance Department. Additionally, they should be required to have some kind of local staffing presence with the authority to resolve problems or disputes. We all know how frustrating it is to get lost in an endless cycle of "press 1 for . . . " or waiting on hold. We want to ensure Oklahoma physicians have a local point of contact to resolve such concerns and, if the dispute cannot be resolved, a process by which they can appeal to the Oklahoma Insurance Department for assistance.

The only way for Oklahoma to become a TOP 10 state in health care outcomes is to embrace the accessibility of quality health care statewide. We should not eliminate the accomplished goals attained in the recent years. The OSMA stands strong in support of the Oklahoma Health Care Authority and offers our continued collaboration to help champion efforts to enhance the health of all Oklahomans.

Please let us know how we can best be of service!

Sincerely,

George Monks, MD, President
Oklahoma State Medical Association

SoonerCare Comprehensive Managed Care Program

Request for Public Feedback in Program Design

Planned Comprehensive Medicaid Managed Care Implementation

Submitted to:
Oklahoma Health Care Authority
Request for Public Feedback—80720200002
Procurement@okhca.org
August 17, 2020 at 5:00 pm Central Time

Submitted by:
Molina Healthcare of Oklahoma, Inc.
Mike Easterday, VP, Business Development
Michael.Easterday@molinahealthcare.com

August 17, 2020

Kevin Corbett, CEO
Oklahoma Health Care Authority
Procurement@okhca.org
Via Email; Delivery Receipt Requested

RE: SoonerCare Comprehensive Managed Care Program: Request for Public Feedback in Program Design, Planned Comprehensive Medicaid Managed Care Implementation, 80720200002

Dear Mr. Corbett:

Attached is Molina Healthcare of Oklahoma, Inc.'s (Molina's) response to the Oklahoma Health Care Authority's (OHCA's) SoonerCare Comprehensive Managed Care Program: Request for Public Feedback in Program Design. We appreciate OHCA's thoughtful approach of soliciting input to best inform the state's future request for proposal.

Reimagining Oklahoma's Medicaid program is a complex undertaking. As an MCO dedicated solely to administering exceptional care to members covered by government contracts, Molina believes managed care is the best option available to achieve Oklahoma's payment and delivery system reform goals to improve enrollee health outcomes and satisfaction; move toward value-based payment; contain costs through better coordination of services; and increase cost predictability for the state.

Our attached response provides best practices, expertise, and recommendations on the areas where OHCA requires additional input to successfully transform the Oklahoma Medicaid program into a comprehensive managed care model. These responses are informed by Molina's more than 25 years of experience as a Medicaid MCO and our current experience gained by serving more than 3 million Medicaid members in 14 Medicaid health plans nationwide. We appreciate this opportunity to provide feedback, and I am available to answer any additional questions.

Sincerely,

Michael Easterday
VP, Business Development

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Managed Care Enrollees

Questions for Stakeholder Input: Managed Care Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Molina shares OHCA's commitment to improving the health and quality of life for all Oklahomans as the state transitions from fee-for service (FFS) to managed care. Our recommendations reflect our understanding of Oklahoma's healthcare budget and long-term vision as described in the Strategic Plan 2018–2022. Our recommendations are based on our analysis of Oklahoma's demographics and potential SoonerCare enrollees, our familiarity with Oklahoma FFS, and our understanding of the challenges states frequently encounter when transitioning to managed care.

Transitioning Aged, Blind, or Disabled (ABD) and Other Initially Excluded Individuals to Managed Care

How and when should OHCA transition ABD and other initially excluded individuals to managed care?

Based on more than 25 years of experience partnering with states to transition healthcare for Medicaid special needs populations from FFS to managed care, **we recommend a three-phased approach using the following timeline:**

- **Year One:** Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), and American Indian / Alaska Native (AI/AN) populations
- **Year Two:** Serious mental illness (SMI) and ABD populations without long-term services and supports (LTSS) needs
- **Year Three:** Dually eligible and LTSS

This timeline is designed to mitigate implementation of all populations by ensuring adequate state resources and time to facilitate stakeholder engagement, including establishing consistent communication and data sharing; provider contracting, training, and claims testing for the populations served; and facilitating ongoing coordination with impacted state and community agencies to ensure a seamless transition for all enrollees. **In Year One, we recommend MCOs form advisory committees to inform health plan programs and policies through feedback from stakeholders to understand what is meaningful and valuable to SoonerCare enrollees and understand provider concerns and challenges.** Finally, the three-year transition gives all stakeholders time to implement and improve on foundational administrative policies and care practices to deliver high-quality healthcare under a financially predictable model.

Stakeholder engagement and collaboration is key to successfully integrating complex needs populations into managed care and provides an opportunity for OHCA and MCOs to proactively address concerns and program risks. **We recommend OHCA consider the following:**

- Select MCOs with **experience across all populations (TANF, SPMI, ABD, LTSS, dually eligible, and more).**
- Select MCOs with a **proven track record of collaboration with state partners and fellow MCOs** and a history of effectively engaging providers, their trade associations, and community-based organizations (CBOs) as well as enrollees and their advocates.

- **Facilitate joint state/MCO stakeholder engagement forums and an OHCA/MCO advisory group** to take action on key opportunities.
- **Collaborate with MCOs on implementation support** through meetings held at least monthly to ensure transition activities are well planned and carried out on schedule.

Enrollment of All Populations

Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

Molina recognizes the advantages and benefits of the various ways MCOs serve diverse populations in meeting the tailored needs of a state and its Medicaid enrollees. Managed care delivery ranges from comprehensive models where most populations are included to models where states exclude populations or offer FFS or limited benefit plans that focus on certain subpopulations (for example, children in foster care, AI/AN, or people with SMI). HealthChoice Illinois, Texas STAR+PLUS, and Ohio Medicaid are just a few examples of programs that integrate the vast majority of services or populations into a comprehensive contract. The advantages of such an approach include coordinated care delivery, budget predictability, and administrative simplification. States such as Florida and New York have distinct, population-specific programs often driven by historical preference for care models or stakeholder beliefs regarding MCOs' ability to assume risk for more specialized populations.

While Molina recognizes the value of specialty plans, **we recommend OHCA require MCOs to enroll all populations to ensure individuals receive services and programs tailored to their needs in an integrated way. OHCA should select MCOs with experience serving specialty populations in a whole-person manner to effectively manage SoonerCare's culturally diverse population.** MCOs with this experience can offer effective strategies and programs; share best practices and lessons learned; and work with OHCA to enhance Medicaid managed care to meet state priorities. Integration of AI/AN populations can be especially challenging, and with more than 145,936 SoonerCare AI/AN enrollees in the state, it is important MCOs demonstrate their experience forming meaningful partnerships with Indian Health Clinics where many AI/AN individuals receive culturally appropriate care and services.

Another consideration for OHCA, if choosing to require MCOs to enroll all populations, is the rate structure. Managed care programs that include specialty populations must establish a rate structure that accounts for the acuity of various populations. In developing a capitation rate structure based on population and acuity, the state will proactively ensure it is paying MCOs based on actuarially sound practice and principles.

However, if OHCA decides to carve out populations with small numbers of enrollees like foster care, we suggest OHCA select a single MCO per specialty plan and select that MCO from the awarded SoonerCare MCOs. In selecting only one MCO to serve an entire specialty population, the MCO can provide better access and quality outcomes to their members and develop a more robust specialized training program for staff and providers than if multiple MCOs administered the specialty plan.

Engaging Individuals in Their Healthcare and Healthy Behaviors

How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Engaging individuals in their healthcare, improving health literacy, and helping enrollees navigate their benefits are keys to motivating them to strive for optimal health. MCOs can play a valuable role in connecting the dots between healthier outcomes and the choices enrollees make, such as seeing a doctor regularly for preventive care, the benefit of screenings, quitting smoking and tobacco use, and eating healthier.

To engage individuals in their healthcare and healthy behaviors, we recommend OHCA selects MCOs with experience in the types of strategies described below. These strategies reflect community partnerships and a strong continuum of wellness supports, communication, and outreach that recognizes the full range of individual preferences that have shown to better engage individuals in their healthcare and healthy behaviors. MCOs should be agile to react to situations like COVID-19 to connect enrollees to the care they need close to home and find effective ways to communicate sound, evidence-based guidance to enrollees. **We recommend MCOs incorporate a broad array of individual engagement strategies that address variations in individual demographics, clinical needs, and personal preferences.** MCOs must be able to continually evaluate the effectiveness of current strategies and their applicability to their membership to ensure they are meeting the changing needs of enrollees. **OHCA should partner with MCOs whose enrollee engagement strategies include:**

- **Partnering with providers.** We acknowledge the role providers play in motivating enrollees to make better lifestyle choices. Studies suggest individuals feel more comfortable discussing lifestyle choices with their primary care provider (PCP).[1] Research into what motivates individuals to make healthier choices, such as quitting tobacco use, losing weight, increasing activity, or limiting alcohol consumption, shows PCPs have a unique opportunity to "nudge" individuals and make reasonable arguments for change.[2] OHCA should select MCOs who have proven, successful approaches to partnering with providers to understand what works in motivating enrollees and brainstorm initiatives that build on this knowledge. Providers should be rewarded for improved quality outcomes with value-based payments to incentivize progress in increasing preventive care among their patients, successfully referring enrollees to tobacco cessation programs, or helping enrollees lose weight through nutritional guidance.
- **Maintaining a broad continuum of wellness initiatives.** This includes health screenings; programs that encourage timely receipt of EPSDT, maternal and child health, preventive, behavioral health, and chronic condition screening services; self-management programs and tools; tobacco cessation; and medication adherence. Care management programs should focus on promoting wellness and preventive services tailored to individuals' strengths, preferences, and needs. Specific initiatives should address mental health and substance use disorders using an approach that enables enrollees to seek treatment when they are ready. Health education should address Oklahoma's population health priorities such as heart disease, cancer, obesity, smoking cessation, stroke and diabetes.
- **Adopting comprehensive communication strategies.** Strategies should include expansive approaches to age-appropriate preventive and wellness services that reach all individuals through various channels, including text and email messaging, mobile apps that personalize wellness alerts, an engaging enrollee website, targeted mailings, and outreach calls. To enhance wellness and benefit messaging, **we recommend OHCA assess the volume of required communications**. In our experience, states that require a defined minimum number of communications often crowd out those focusing on engagement in wellness activities.
- **Deploying face-to-face engagement activities for individuals with complex needs** or extensive unmet social needs, such as community health workers and other community-based supports, who can engage with homeless enrollees when appropriate, as these individuals may be difficult to reach. The focus should be on identifying and removing barriers to accessing care.

[1] Shi, Leiyu, "The Impact of Primary Care: A Focused Review," *Scientifica*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/, December 31, 2012, accessed August 11, 2020.
[2] Alemanno, Albert, "Public Health: How to Encourage People to Lead a Healthier Lifestyle," HEC Paris, https://www.hec.edu/en/knowledge/instants/public-health-how-encourage-people-lead-healthier-lifestyle, September 15, 2012, accessed August 11, 2020.

- **Collaborating with CBOs, state agencies, advocacy groups, and schools** to amplify messaging and offer community-based services that are convenient for individuals. MCOs should partner with those agencies and organizations who serve Medicaid-eligible individuals to connect with those who have known disparities.
- **Implementing meaningful enrollee incentives.** Incentive programs should be meaningful for enrollees and encourage healthy behaviors, such as timely receipt of wellness care and recommended health screenings. MCOs can motivate enrollees to reach their goals by helping them formulate measurable goals that tie back to their personal values and what is important in their lives.

Benefits Provided Through MCOs

Questions for Stakeholder Input: Benefits Provided through MCOs

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

As Oklahoma transitions to managed care, some individuals may not always be comfortable accessing care, may not know how to navigate the system, or may experience gaps when being served by multiple providers or agencies. We encourage OHCA to use the RFP process for MCOs to demonstrate strategic and innovative approaches to access to care and benefits that ultimately increase enrollee engagement, improve programs and outcomes, and enhance wellness behaviors for individuals and their families.

Helping Individuals 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?

Ease of access is of particular concern in the rural parts of Oklahoma, with 70 of 77 counties classified as Medically Underserved Areas. As OHCA works with MCOs to make access to care easier, especially in rural parts of the state, **we recommend OHCA:**

- **Broaden provider definitions.** For many routine or even urgent physical health and behavioral health appointments, telehealth can serve the same purpose as an in-person appointment. As part of the effort to broaden the number of available providers, OHCA and MCOs can encourage and offer incentives for providers who work to the top of their license.
- **Allow MCOs to cross-contract with bordering states.** In many cases, providers are more readily available across state lines. For instance, an enrollee in Southeast Oklahoma is likely to be closer to a provider in Dallas than to one in Oklahoma City or Tulsa. This increased access would benefit both Temporary Assistance for Needy Families (TANF) and Aged, Blind, or Disabled (ABD) populations.
- **Require MCOs to leverage mobile and related communications technologies.** By giving enrollees an app that includes their health information and reminders for scheduled necessary appointments and immunizations, as well as message or chat that can connect them with a member services representative, MCOs can drive population health and prevention efforts.

For years, Oklahoma has worked to address provider shortages and has stayed ahead of the national curve on implementing innovative technologies, such as telehealth and the health information exchange. A managed care program with MCO partners committed to investing in technology and working with providers aligns with the state's efforts and will help individuals access the care they need.

Resolving Problems with Accessing Care

Oklahoma has been a national leader in embracing technology, with parity laws long in place for telehealth (including for reimbursement rates) and with the removal of restrictions such as the patient's location during service. This practice has been especially helpful to bridging gaps for behavioral health

providers. COVID-19 has prompted the temporary expansion of telehealth as a benefit across the nation. **We recommend a workgroup with the Office of Telehealth and the Telehealth Alliance of Oklahoma to bring OHCA, MCOs, and provider groups together** to ensure this extended coverage becomes permanent and far-reaching to help Medicaid enrollees connect to the services they need.

We recommend OHCA approve telephonic visits in areas without broadband access. According to a 2019 FCC study, 95% of Oklahomans in urban areas have adequate broadband access, but only 48% of rural Oklahomans do. Telephonic visits are already approved for Medicare during the public health emergency and adding this service to SoonerCare would significantly reduce coverage gaps, particularly for behavioral health.

For in-person care, non-emergency medical transportation (NEMT) is essential to solving access issues, particularly in the Southeast and Western portions of the state. **We recommend NEMT be administered by MCOs.** Enrollees report higher levels of satisfaction in states where MCOs administer the NEMT benefit. NEMT brokers that have worked with health plans in Oklahoma and/or throughout the nation have developed communication protocols and reporting systems that ensure the capture of encounters and other data that helps monitor fraud, waste, and abuse and maintain program integrity. This data is more accurate and timelier. NEMT would include public transportation, family/friend mileage reimbursement, and ride-sharing services as necessary and appropriate. NEMT is an integral part of the effort to increase enrollee access by cross-contracting with providers in other states.

Further, we recommend the elimination of requirements for prior authorization for some outpatient behavioral health services. This will reduce providers' administrative burden and improve enrollees' ability to receive timely services.

Strategies to Improve Integration of Services

What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Integration of services—incorporating physical health and behavioral health into a single care model that also addresses social determinants of health (SDoH)—is the hallmark of an MCO that best serves Medicaid individuals. **We recommend the state continue to include a continuum of care for behavioral health as covered benefits as it moves to managed care.** MCOs with in-sourced, non-delegated integrated care offer streamlined operations and easier sharing of information and treatment plans among providers in all disciplines. As part of its evaluation of MCOs' behavioral health operations and expertise, OHCA should seek information on the results of their procedures to ensure parity according to the Mental Health Parity and Addiction Equity Act.

Integration Through Provider Communication

An integrated model of whole-person care ensures providers exchange information with one source instead of two or more. In addition, MCOs with in-house behavioral health services can offer expertise to primary care providers (PCPs) and other providers who may not be experienced in treating behavioral health concerns. **We recommend MCOs be required to continually demonstrate how their education and communication strategies enhance PCP knowledge of behavioral health services.** Methods of distributing this information should include:

- Regular participation in regional provider and/or association meetings
- Face-to-face provider visits
- Formal committees with health systems, hospitals, and large provider groups
- Provider bulletins and blast email/fax publications
- Provider Manual updates
- Announcements on the provider portal landing page

Updates to providers should include procedural information (awareness of new state or MCO forms, for instance) as well as education about evidence-based practices and research into Medicaid-related topics throughout the nation. For instance, our experience suggests providers do not complete screenings for a variety of reasons. These reasons span from instances where their professional determination concludes that a screening is not warranted to absence of reimbursement for completing screenings. An MCO's education efforts can help remove this barrier to enrollees receiving the care they need.

MCOs should be fully staffed with a locally based Provider Services team that meets face to face with providers throughout the state. This strategy is effective for building relationships that lead to implementation of targeted programs and interventions to address specific needs within a region, including provider incentive programs. **We recommend MCOs offer incentives to providers who offer physical health and behavioral health services during the same visit.**

Integration Through Shared Assessments and Planning

Sharing assessments and care planning among all providers and with MCOs allows providers to learn from one another, collaborate more effectively, and communicate using the same language and references. This best practice improves efficiency and allows for better data analysis. To promote this effort, **we recommend OHCA require MCOs to use nationally recognized, evidence-based tools to screen individuals for behavioral health needs (for example, the CAGE-AID for substance use disorders [SUD] and the PHQ-9 for depression) and offer reimbursement for their utilization.**

A key part of the success for shared assessments is PCPs having access to the tools and being trained on how and when to use them. With this access and training, PCPs perform more assessments and are better able to identify patients with mental health or SUD conditions that require treatment. This leads to appropriate referrals and more active care management.

Our experience shows this process of shared assessment and PCP engagement works more smoothly under an MCO that offers in-house behavioral health services, as it removes the complication of having different sources of information for physical health and behavioral health. The multidisciplinary nature of an MCO with in-sourced behavioral health leads to quicker and easier enrollee access to specialized services. The goal is to ensure enrollees are cared for in a truly whole-person-centered manner.

OHCA may also consider requiring a standardized SDoH screening tool. Standardized SDoH assessments ensure a consistent approach for collecting information; ease provider administrative burden caused by multiple assessment forms; and facilitate population-level analysis for MCOs to assess individual needs and design and implement targeted solutions to address them.

Integration Through Data Sharing

Meaningful care coordination and more effective workflows rely on seamless exchange of data between providers, specialists, the state, and the individuals MCOs serve. Without adequate sharing, there can be information gaps that inhibit or delay needed services and care management. This is especially true if physical health and behavioral health come from different sources and do not provide the full picture of the enrollee's health status.

Molina recommends that in advance of introducing managed care, OHCA convene a workgroup involving all awarded MCOs, providers, and other stakeholders. This workgroup would agree on platforms and parameters for data exchange with OHCA for historical perspective and MCOs for claims, hospitalizations, authorizations, and pharmacy. Agreeing to platforms and parameters will promote more efficient sharing of information across healthcare specialties.

To promote meaningful data sharing among MCOs and with OHCA, **we recommend OHCA:**

- **Partner with MCOs to help continue and enhance meaningful efforts in promoting providers' use of electronic health records (EHRs).** Cloud-based portable EHRs, one of many emerging technologies, is an innovative way to connect individuals, caregivers, system partners, and providers via secure login. This technology drives secure, real-time, appropriate, and timely information gathering, including:
  - Screening and assessment information
  - Immunization records
  - Current medications and prescribers
  - Information about the individual's overall health status such as conditions under treatment, height, weight, recent medical visits, allergies, and lab results
  - Contact information for the individual's PCP, specialists, dental providers, and behavioral health providers
  - Health alerts for upcoming screenings, medication refills, and gaps in care
- **Standardize data elements** to enable MCOs to identify critical risk factors while monitoring and assessing progress toward identified goals.
- **Implement a statewide screening tool** that allows providers to identify health and social risk factors for comparison and standard information exchange.
- **Standardize MCOs' data analytics requirements** to include items from the screening tool, such as percent offered at screening, percent of screening complete, percent of individuals identified as needing a referral, and percent of individuals receiving referrals.

Care planning that involves the enrollee, an MCO care team, and community or agency case managers, as well as all providers and social workers deemed necessary and acceptable to the enrollee, requires that an MCO's management information system be highly configurable. This promotes access, inquiry, and bidirectional sharing of information from disparate data sources while complying with state and federal requirements. MCO system architecture and platforms should provide OHCA and other program stakeholders (individuals, Care Management team participants, providers, and subcontractors) with superior operational functionality and ensure secure, HIPAA-compliant exchange of health information.

Facilitating Referrals to Social Services and Tracking Outcomes

How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

A key to achieving OHCA's strategic goal to minimize health disparities is to break down barriers between the SDoH domains to address social risk factors and individuals' social needs. **We recommend OHCA partner with MCOs that:**

- **Have formal referral processes and systems**
- **Demonstrate a track record of building meaningful partnerships with community-based organizations and agencies with bidirectional referral processes**
- **Utilize data from a variety of sources to identify health disparities, risk factors, and social needs to generate referrals**
- **Demonstrate outcomes of SDoH referrals, programs, and interventions**

To ensure MCOs devote sufficient resources to social risk mitigation strategies, **we recommend OHCA consider activities related to social services in setting capitation rates**. Addressing enrollees' SDoH needs requires MCOs to invest in hiring and training employees and manage assessments and referral networks specifically targeting non-medical interventions.

Measuring MCO Performance on Social Risk Factor Mitigation Strategies

We recommend OHCA evaluate health measures that correlate to social risk factor mitigation strategies. This approach leverages robust, existing indicators to understand the results of SDoH programs and practices on individuals' health without adding undue administrative burden to OHCA or providers. Some programs rely on process measures such as count of referrals per 1000 enrollees, which demonstrates the volume of activities. However, this method does not ensure the activities achieve OHCA's goals, and it adds monitoring burden to OHCA contract management.

As an example of evaluating social supports through their impact on health outcomes, consider the 2019 Oklahoma Minority Health at a Glance report, which emphasizes reducing infant mortality. The 2017 infant death rate among non-Hispanic Black women was more than twice that of non-Hispanic White women. To address this disparity, MCOs must address not only prenatal and postpartum medical care but also risk factors such as health literacy, nutrition, transportation access, safety of the home environment, and lifestyle factors such as smoking and other substance use. Efforts should be measured not merely by the number of pregnant women engaged but by improvements in HEDIS rates.

In addition, **we recommend OHCA require MCOs to report the results of mitigation strategies from specific pilots or programs,** such as a reduced rate of homelessness or an increase in the percentage of providers submitting SDoH information on claims. Since SDoH risk factors like literacy, employment, and housing span social infrastructure domains, this transparency provides OHCA insights that may shape intra- and inter-agency policy and fiscal planning.

Improving Access to Evidence-based Behavioral Health Care

How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

To improve access to evidence-based behavioral health care, **Molina recommends OHCA:**

- **Expand inclusion criteria to include a "No Wrong Door" approach**, whereby a referral can come from any internal or external entity, including self- or enrollee-family referral.
- **Require trauma-informed modeling.**
- **Expand the availability of screenings by non-behavioral health providers with MCO reimbursement.**
- **Continue support of current OHCA initiatives** such as assertive community treatment, medication assisted treatment (MAT), and peer supports.

Molina recommends OHCA require MCOs to use and report on nationally recognized, evidence-based tools to screen individuals for behavioral health needs (for example, the CAGE-AID for SUD and the PHQ-9 for depression). These standardized assessments will help ensure a consistent approach to collecting information and ease provider administrative burden caused by multiple assessment forms. It will also facilitate population-level analysis for MCOs to assess individual needs and design and implement targeted solutions to address them.

Collaborating with and educating providers is central to improving access. MCOs should partner with OHCA to educate providers on available assessment tools and appropriate use of the tools to increase the number of PCPs providing screenings. Furthermore, **we recommend OHCA require MCOs to reimburse providers who submit valid claims for completing screenings** using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool, as well as nationally recognized tools such as CAGE-AID, PHQ-9, and the Edinburgh Postnatal Depression Scale (EPDS). If screenings are a covered, reimbursable service, MCOs can use claims-level data to monitor completion rates and conduct outreach and education to PCPs who are not actively submitting claims for screenings.

We recommend OHCA require MCOs to administer the MAT benefit. Experience in delivering this benefit is essential for ensuring its appropriate use. MCOs should have a track record of supporting, shaping, and improving provider performance by engaging in regular outreach to:

- Promote the adoption of alternative payment options (for example, P-COAT).
- Help connect providers to mentors, such as those trained through SAMHSA's Providers Clinical Support System (PCSS) project. PCSS trains healthcare professionals to provide effective, evidence-based MAT to patients with opioid use disorder (OUD) in primary care, psychiatric care, SUD treatment, and pain management settings.
- Support the expansion of the MAT footprint through the inclusion of OUD treatment programs and other clinical venues.
- Include TeleMAT services to support maintenance of the emergency guidelines governing telehealth and SUD services.
- Educate providers on using MAT services for both OUD and alcohol addiction.
- Educate providers on how to appropriately engage and bill for telemedicine services.
- Contract with telemedicine providers that provide outpatient addiction treatment services, including MAT, to fill gaps in access to treatment across the state.
- Support providers in clinical decision-making and practice transformation through education and tools.

Molina supports the Oklahoma Department of Mental Health and Substance Abuse Services' Programs of Assertive Community Treatment (PACT) provided by community mental health centers (CMHC) to serve people with more intensive psychiatric needs in the community. **We recommend OHCA extend assertive community treatment as a covered service outside of the CMHC setting.** This will increase enrollee access by adding providers who can perform outpatient behavioral health services but are not federally designated and funded as CMHCs.

In addition to PACT, current SoonerCare benefits include a comprehensive array of crisis services such as mobile crisis, facility-based stabilization, community-based structured emergency care, and ambulatory detox. **Molina recommends mobile crisis services be considered covered benefits for adults, adolescents, and children statewide.**

We recommend two additions to the current list of covered benefits for crisis services:

1. **Molina recommends OHCA reimburse for short-term crisis shelters for children and peer-run respite centers for adults.** Short-term crisis shelters offer temporary shelter and crisis intervention for adolescents and children who have run away from home, are threatened, or are alleged to be abused or neglected. Similarly, peer-run respite centers provide voluntary short-term stays for adults experiencing emotional distress. Reimbursing for these benefits is a more cost-effective way to provide access to short-term crisis stabilization than an inpatient psychiatric admission, which is often the only treatment setting available.
2. **Molina recommends psychiatric residential treatment facility coverage for all enrollees** with mental health disorders, both under and over age 21, as well as coverage for residential treatment for all enrollees with SUD.

Value-added Services

What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

Value-added services can positively affect health outcomes, prevention, and/or enrollee satisfaction. Value-added services can include increased medical services, such as an offering beyond EPSDT requirements, extra vision and physical health benefits, or recovery and rehabilitation services. It can also include equipment/supplies and incentives for enrollees who complete preventive care.

We recommend that when scoring MCOs' RFP responses, OHCA assess bidders based on the proven results of their value-added services. For each value-added service offered, MCOs should specify how enrollees are identified for that service, how they might benefit, and the requirements in place to obtain these value-added services. In addition, the full package of an MCO's value-added services should address SDoH. **We further recommend the state monitor utilization of value-added services to track improvements in enrollees' conditions and the cost of care among those enrollees.**

Access to Transportation

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

We recommend MCOs administer the SoonerCare transportation benefit. MCOs and NEMT brokers have long-standing relationships and system interfaces that enable the seamless sharing of data for monitoring and quality improvement purposes. OHCA should require MCOs to offer flexible scheduling methods—online, by phone, and through a mobile app—combining traditional NEMT with newer ride-sharing options. By leveraging MCOs' existing procedures with NEMT brokers, OHCA will receive transparent and thorough reporting that ensures optimal and appropriate use of this benefit by enrollees.

As one illustration of the advantage of having MCOs administer the transportation benefit, consider the performance of one national NEMT broker:

- 26% savings compared with similar mileage trips with traditional providers
- Improved on-time performance
- Average response time of seven minutes
- Reduction in grievances
- Increased enrollee satisfaction

OHCA should consider that the volume of NEMT services increases after a transition to managed care because the service improves and MCOs eliminate most of the barriers. OHCA must implement cost controls to account for this increased volume. Two proven cost-control measures are: 1) enforcing public transportation as the primary mode of transport unless contraindicated by the enrollee's condition at the time of service; and 2) mileage reimbursement for the enrollee's friends and family who can provide rides to and from areas that are not accessible by public transit and at a lower price than Lyft or Uber.

Ride-sharing Services

We recommend OHCA allow for ride-sharing services subject to prior authorization requirements. Uber and Lyft serve an important role in filling the gaps when public transportation and friend/family mileage reimbursement are not available.

The NEMT benefit should extend across state lines if an MCO can connect an enrollee to an in-network provider. This would be particularly helpful in the Southeast, where many individuals are closer to providers in Dallas than they are to Oklahoma City or Tulsa.

Quality and Accountability

Questions for Stakeholder Input: Quality and Accountability
- What mechanisms should the state use to incentivize MCOs to improve member outcomes?
- What are the most important indicators of MCO performance? Why?
- What measures of health outcomes should be tracked?

Molina supports and encourages OCHA's use of incentives to align MCO strategies with its leading health priorities. In the experience of our Medicaid affiliates over the past 25 years, incentives such as quality pools are an effective means to achieve sustainable improvements in Medicaid programs. **In addition to overseeing an MCO incentive program, we recommend OHCA use the upcoming RFP to assess each MCO's experience and plans to drive improvement through provider incentives.** Aligning the incentives of MCOs and providers will help OHCA create a culture of continuous improvement that benefits all SoonerCare enrollees.

Mechanisms to Incentivize MCOs to Improve Member Outcomes

What mechanisms should the state use to incentivize MCOs to improve member outcomes?

In our experience, the most effective incentives are those that recognize MCOs' need for financial stability while also holding MCOs accountable to address the health conditions that are most significant for a state's unique populations and the needs of its enrollees. In that light, **we recommend OHCA implement the following mechanisms to incentivize MCOs:**

Establish attainable targets prior to the effective date of each Contract year. Establishing attainable targets in advance of each year allows MCOs time to plan and execute strategies to achieve OHCA's desired goals. Incentives should begin in Year 2 of the Contract, allowing one year to establish consistent baselines across MCOs. Targets should emphasize year-over-year improvements rather than HEDIS percentile rankings. Targets for underperforming measures in subsequent years should be set 5% higher than the highest-performing MCO from the previous year. If MCOs are performing at or above the 90th percentile for a measure, the measures should be adjusted to focus on other areas or allow all plans to obtain full credit since all plans are high performing.

Create actuarially sound base rates and offer incentives as a complement to those rates. Capitation rates must ensure MCOs remain on solid financial footing. Beyond capitation rates, structuring a tiered percentage approach to incentives encourages MCOs to continue efforts to improve relative to the target even if the MCO does not expect to meet the target.

Consider adding incentives for MCOs to expand use of alternative payment models. We recommend OHCA reward MCOs as they move contracted providers along the value-based payment continuum. Providers are at different places in their desire and ability to assume varying levels of risk. MCOs therefore must be able to meet the provider where they are to ensure provider performance success and achieve the best outcomes for enrollees. **We further recommend OHCA work with MCOs to establish a value-based care advisory committee to ensure alignment and develop viable initiatives to reduce provider abrasion.**

Consider rewarding top-performing MCOs with a greater share of new enrollees through the auto-assignment algorithm. We recommend with respect to auto assignment, for the first two years, the quality metrics be reported for informational and educational purposes only. This will enable MCOs to design and implement strategies to best meet enrollee healthcare needs to drive optimal health and well-being. At the end of year two, OHCA can execute an enrollee assignment methodology that includes quality as a factor. The methodology should be employed when a Medicaid enrollee does not actively

choose an MCO and cannot be matched to an MCO based on previous MCO enrollment or that of a family member. **We recommend OHCA review the quality-based assignment algorithm at least annually and adjust as needed.** While quality should be an important part of the algorithm, efforts should be made to allow enrollees previously covered by an MCO to return to that MCO as well as ensure an enrollee's primary care provider (PCP) is part of the MCO's network to which they will be assigned.

Most Important Indicators of MCO Performance

What are the most important indicators of MCO performance? Why?

To create a smooth entry into managed care for all stakeholders and establish a quality program that best serves enrollees and drives improvement, **we recommend OHCA use nationally recognized metrics, such as HEDIS, as indicators of MCO performance.** Widely used and accepted, HEDIS performance measures offer an objective and validated approach to consistently measure quality across MCOs. This consistent set of performance metrics and standards should result in better alignment in performance goals among MCOs and providers. We urge OHCA to avoid using non-HEDIS measures, such as utilization rates, which are not included in the HEDIS performance measurement set, may pose challenges in reporting, and are susceptible to variances in measurement.

National benchmarks offer significant advantages over state-specific measures, including:

- Ensuring providers face minimal additional administrative burden; many providers, in particular patient-centered medical homes (PCMHs) with sophisticated information systems, already capture and report HEDIS data
- Establishing a level playing field among MCOs and providing consistent performance measurement
- Ensuring MCOs can leverage existing operational capabilities to achieve OHCA's health priorities in a cost-effective manner; for example, CMS' new "Primary Care First" PCMH model is already in place and standardized for most MCOs and would incentivize providers to quickly achieve a mature PCMH aligned with NCQA standards

The metrics are adjusted annually to reflect national performance and will ensure Oklahoma is continually aligned with national trends and targets. This is consistent with the Governor's goals to improve Oklahoma enrollees' health status not only year over year within the state but in comparison with the rest of the nation.

If OHCA uses quality as a factor in auto assignment, we recommend the methodology entail a point-based algorithm based on HEDIS measures that considers better performing MCOs, most improved MCOs, and whether the MCO scores above the 90th percentile of the measure's benchmark. However, the state's auto-assignment process should include a time period for enrollees to return to an MCO in which they were previously enrolled or an MCO that includes access to a preferred PCP to ensure enrollee preference in their MCO assignment.

Health Outcomes Measures to Track

What measures of health outcomes should be tracked?

We recommend OHCA require MCOs to report the following quality measures in Table 1 to evaluate program effectiveness. These measures align with the state's healthcare priorities, are well understood by MCOs as well as providers, and have a track record of showing population health improvements. Because they are nationwide measures, they offer a baseline for comparability both among MCOs and among states.

Table 1. Recommended Measures of Health Outcomes

State Priority	Recommended Measure
Tobacco Use	Tobacco cessation measure, HEDIS data set, captured within adult CAHPS survey
Childhood Obesity	HEDIS measures: • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Well-Child Visits in First 30 Months of Life • Child and Adolescent Well-Care Visits • Childhood Immunization Status • Immunizations for Adolescents
Opioid-related Overdose Deaths	HEDIS measures: • Use of Opioids at High Dosage • Use of Opioids from Multiple Providers • Risk of Continued Opioid Use
Behavioral Health Access	HEDIS measures: • Follow-Up after Hospitalization for Mental Illness • Anti-Depressant Medication Management
Diabetes	Comprehensive Diabetes Care (HEDIS)
Cardiovascular Disease	HEDIS measures: • Persistence of Beta-Blocker Treatment After a Heart Attack • Statin Therapy for Patients with Cardiovascular Disease
Infant Mortality	HEDIS Inpatient Utilization (to identify discharges for infants less than 1 year of age to determine if there are outliers that should be evaluated)
Pregnancy Outcomes	HEDIS measures: • Prenatal and Postpartum Care • Breast Cancer Screening and Cervical Cancer Screening (to ensure adequate focus on women's health)

Care Management and Coordination

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
- How can MCOs improve the management and coordination for members with chronic or complex health conditions?
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Molina has reviewed the OHCA Strategic Plan 2018–2022 and supports OHCA's vision, mission, and goals. Our recommendations within this document are based on our more than 25 years of experience as a Medicaid MCO and our current best practices gained by serving more than 3 million Medicaid members in 14 Medicaid health plans nationwide. These recommendations ensure OHCA will be set on a path of success when working with MCOs to build a quality provider network and a system of care delivery based on evidence-based guidelines and best practices, and ensure coverage and enrollment are appropriate—all to meet the goal of improving the health of Oklahomans.

Utilization Management Tools to Benefit Members and Providers

How can utilization management tools work best for members and providers?

Molina fully supports OHCA's goals of Responsive Programs. An evidence-based utilization management program is key to supporting providers and enrollees in achieving optimal health outcomes, controlling healthcare spending, and achieving predictable results.

When selecting MCOs and evaluating their utilization management programs, **we recommend OHCA consider requiring MCOs use evidence-based guidelines from reputable, industry-recognized vendors and requiring guidelines be available and easily accessible to both enrollees and providers to ensure transparency in decision-making.**

OHCA should also assess MCOs for:

- **How they leverage evidence-based guidelines as the foundation for their utilization management policies**
- **Their ability to innovate and use technology to streamline utilization management to improve the provider and enrollee experience**
- **Their capability to facilitate provider engagement in the utilization management process**

Benefits to providers. A comprehensive utilization management program enhances providers' overall experience with the MCO and helps them improve quality of care. The use of familiar, industry-leading, evidence-based criteria enables providers to focus on enrollee care rather than on plan administration. Utilization management guidelines provide consistency but allow providers the tools and standards to deliver individualized, quality care for each of their patients. Providers should be able to quickly and easily access guidelines to facilitate timely intervention and address enrollees' needs through appropriate, effective treatment protocols.

OHCA should look for MCOs that innovate with provider-friendly technology such as automated decision-making tools and easy-to-navigate provider portals. By applying best-in-class technology to streamline utilization management decisions, MCOs can reduce provider administrative burden, speed claims adjudication and provider payment, and help promote close-to-real-time authorization requests.

Clear policies, transparency, and technology lead to efficiency, which directly benefits providers, who can see more patients in a given time and control administrative costs. **We recommend MCOs should have robust provider support to guide providers in how to request authorizations, file claims, check claims status, and review their rights and responsibilities.** MCOs should also be able to demonstrate how they engage providers to impact policies and quickly respond to emerging practices. Provider training and support should be flexible in engaging various types of providers throughout Oklahoma, from home- and community-based services providers to large hospital systems, physician practice groups, and individual practitioners to respond to their various levels of administrative sophistication.

Benefits to enrollees. Utilization management, when transparent, consistent, and evidence-based, is central to person-centered care coordination that addresses the full range of enrollee needs. It also gives enrollees insight into how their care is being administered and how clinical decisions are made. When providers are given the tools and support they need, such as industry-recognized, evidence-based guidelines or technology to streamline authorizations, enrollees receive care timelier and may be confident they are consistently receiving appropriate care across providers and facilities. Utilization management promotes enrollee safety by ensuring they receive the right care, at the right level of service, in the right setting, such as ensuring enrollees get home when it is safe to do so rather than having them remain in the hospital. Finally, use of guidelines and utilization management policies, which leverage those guidelines, can help address health disparities by ensuring clinical care is consistent across patient groups.

Consistency Across MCOs in the Utilization Management Process to Reduce Provider Administrative Burden

How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

Reducing provider abrasion is crucial to maintaining providers in the Medicaid network and facilitating OHCA's strategic objective of maximizing cost efficiency and health outcomes related to managed care efforts. **We recommend OHCA provide an environment that facilitates open communication and collaboration among MCOs and other stakeholders without being prescriptive**, which can limit innovation in reducing administrative burden and rapidly deploying advances in care.

It is important MCOs show commitment to fostering open communication with other MCOs and providers to understand provider concerns and build consistency, where appropriate and possible. OHCA should provide MCOs opportunities to collaborate to reduce provider administrative burden. To facilitate collaboration, **we recommend OHCA require MCOs participate in monthly meetings with the agency** to evaluate concerns being raised by the provider community and discuss ways to approach consistency across plans. Providers should be listened to and supported as they are the best source for identifying their own challenges.

We also recommend OHCA require MCOs participate in quarterly meetings attended by MCOs' local leadership and select participants from stakeholder organizations to solicit feedback, such as Oklahoma Academy of Family Physicians, Oklahoma Chapter of the American Academy of Pediatrics, Oklahoma Medical Association, Oklahoma Office of Rural Health, the Oklahoma-based chapter of National Alliance on Mental Illness, American Society of Addiction Medicine, Mental Health Association Oklahoma, Heartland Telehealth Resource Center, Oklahoma Hospital Association, Patient Care Network of Oklahoma, and more.

We recommend OHCA choose MCOs with demonstrated experience using feedback from the provider community to deploy successful initiatives that support providers. We suggest OHCA form a provider/MCO collaboration group to establish long-term goals that ultimately support providers, reduce provider burden, and streamline claims and prior authorization request submissions, while

maintaining the health-related and fiscal value managed care affords individuals, stakeholders, and the state. An example of this type of collaborative innovation is MCO adoption of a multipayer provider portal to facilitate and streamline services for providers for all products. Adoption of a HIPAA-compliant, secure provider portal technology across all MCOs addresses the types of issues providers mention most often as causing the most abrasion. Through the portal, providers would be able to:

- Submit and check the status of claims in real time
- Receive electronic funds transfer for faster and safer payment
- Receive remittance advice and explanation of payment
- Complete and receive approval of prior authorization requests
- Confirm enrollee eligibility and coverage details

Fostering communication and allowing for collaboration is key to meeting OHCA's desire for Responsive Programs and builds a foundation of innovation and agility for MCOs to address the challenges Medicaid providers face.

Meeting the Behavioral Health Needs of Enrollees

What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

Oklahoma has some of the highest rates for mental illness and substance use disorders (SUD) in the nation and ranks 16th for self-harm and suicidality. AmericasHealthRankings.org ranks Oklahoma 28th in drug deaths overall, with an estimated 43% of drug overdose deaths involving opioids, totaling more than 308 fatalities (a rate of 7.8/100,000 population). [3] To better meet the needs of Oklahomans and help OHCA with these challenges, **we recommend MCOs be required to:**

- **Increase access to behavioral health care using a variety of strategies and approaches**
- **Support providers through education and training**
- **Explore innovative approaches to care delivery**
- **Use integrated, evidence-based care coordination models**
- **Support current Oklahoma initiatives**
- **Use data for targeted care coordination efforts**

Network Development and Provider Support to Meet Enrollees' Behavioral Health Needs

We recommend OHCA choose MCOs with experience providing customized support for behavioral health providers through training and support as well as reimbursement. Bidding MCOs should have a program to encourage, incentivize, and educate providers on how to perform appropriate, evidence-based screenings to assess individuals' behavioral health and emotional health needs. This provider training also helps to maintain the network by improving the provider experience.

To ensure system-wide screenings are performed using nationally recognized tools, **we recommend OHCA include such screenings as reimbursable covered services.** If screenings are a covered, reimbursable service, MCOs will be able to use claims-level data to monitor completion rates and conduct outreach and education to primary care providers (PCPs) who are not actively submitting claims for screenings.

[3] America's Health Rankings, 2019 Annual Report, United Health Foundation, https://www.americashealthrankings.org/explore/annual/measure/Drugdeaths/state/OK, accessed August 12, 2020.

Increasing Access to Behavioral Health Care and SUD Treatment

As much of the nation has experienced the rise of opioid use, Oklahoma is no exception. To ensure individuals have access to SUD services at the appropriate level of care, **we suggest OHCA consider the following MCO requirements:**

- **Use nationally recognized criteria, such as the American Society of Addiction Medicine (ASAM) guidelines**, to determine the appropriate level of care for individuals with SUD.
- **Collaborate with OHCA and state agencies to educate behavioral health providers and PCPs on appropriate diagnosis, treatment, referral, and utilization of SUD services**, including use of ASAM criteria when there are co-occurring conditions.
- **Remove prior authorization requirements for certain services**, such as behavioral health assessments and outpatient visits and generic medications for opioid and alcohol use disorders.
- **Coordinate with behavioral health providers delivering court-ordered services and services for individuals** released from incarceration and support them in determining the appropriate level of care, admission for services, and discharge planning.

Molina recommends OHCA provide enhanced funding to encourage facilities to provide ASAM Level 2 (Ambulatory Withdrawal Management with Extended On-Site Monitoring) and **ASAM Level 3.7** (Medically Monitored Inpatient Withdrawal Management [Adults] and Medically Monitored High-Intensity Inpatient Treatment [Adolescents]) services. Ambulatory withdrawal management in a structured, therapeutic environment is an effective and less costly alternative to inpatient detoxification. OHCA investments should include paying an enhanced fee for these services for a specified duration to spur providers to offer these services, which would reduce the gap in available services for individuals needing addiction and withdrawal management services.

When there are gaps in the continuum of behavioral health services, we encourage OHCA to allow MCOs to use innovative behavioral health solutions. These alternatives include the use of peer supports from those with lived experience to guide enrollees in recovery, social determinants of health (SDoH) transition services, and In Lieu of Services. Leveraging In Lieu of Services can offer alternatives in geographic areas where there may be limited access to behavioral health providers and include:

- **Ambulatory detox or outpatient detox.** Treatment includes clinical and medical management of physical and psychological withdrawal symptoms (from alcohol and other drugs) on an outpatient basis in a community setting.
- **Subacute detox.** At this level of care, physicians are available 24 hours per day by telephone.
- **Crisis stabilization unit.** Examines and stabilized enrollees; redirects them to the most appropriate and least restrictive treatment setting; and maintains enrollee safety.

COVID-19 has also helped to reveal the value of telemedicine and the viability of telepsychiatry in parts of the country and among individuals that were previously reluctant to adopt the technology. According to research by Frost and Sullivan consultants, March 2020 telehealth visits surged 50% amid the coronavirus pandemic, and analysts now expect visits to top 200 million this year, up sharply from their original expectation of 36 million visits for all of 2020.[4] For enrollees who reside in rural areas or who prefer to see a behavioral health provider in their own home, this expansion of care settings is especially important.

We support Oklahoma's efforts related to primary care case management and patient-centered medical homes statewide in support of integrated care and increasing access for enrollees. This infrastructure provides an excellent foundation for network development while improving the quality of care received by enrollees with serious mental illness (SMI) or serious emotional disorder.

[4] Coombs, Bertha, "Telehealth Visits are Booming as Doctors and Patients Embrace Distancing Amid the Coronavirus Crisis," CNBC LLC, https://www.cnbc.com/2020/04/03/telehealth-visits-could-top-1-billion-in-2020-amid-the-coronavirus-crisis.html, April 4, 2020, accessed August 10, 2020.

Developing Sufficient Provider Network Capacity

Developing additional provider network capacity to better serve enrollees' behavioral health needs and create more points of access requires a comprehensive approach. MCOs should be willing to support and shape provider performance by engaging in regular outreach and incentivize performance. **We recommend OHCA seek out MCOs that offer value-based contracting opportunities for providers who use evidence-based programs and the following approaches:**

- Identify and support training opportunities on evidence-based practices and specific services such as Screening, Brief Intervention, and Referral to Treatment (SBIRT); medication assisted treatment; and assertive community treatment.
- Offer incentives that promote positive enrollee health outcomes.
- Implement enhanced payments to encourage organizations to participate and enable them to hire and train appropriate credentialed staff.
- Offer value-based payments to reward providers for meeting quality and fidelity measures.
- Collaborate with OHCA to develop workforce development efforts, technical assistance, and coaching.
- Use centers of excellence to support expectations related to the knowledge and application of evidence-based practices.

Behavioral Health Care Delivery and Coordination of Care

Many MCOs have outsourced their care coordination and behavioral health services; as a result, enrollees are not provided the level of care coordination that is truly required. Local coordination is critical as is the capability of the MCO to provide in-person support when needed. Below, we provide recommendations based on best practices gained through our experience providing behavioral health services across 14 states.

Integration

It is important OHCA choose health plans that are truly integrated to seamlessly serve enrollees' physical health, behavioral health, and SDoH needs. The gold standard for integrated care is to have integration of an MCO's processes, systems, and teams, as well as an integrated approach to enrollee care coordination. This means all plan services and care coordination are delivered with non-delegated, in-sourced staff that can locally engage within the communities they serve. **We recommend OHCA require of MCOs full, in-sourced, non-delegated integration.**

Our recommendations extend to integrating staff training, use of evidence-based comprehensive assessments, and integrating care coordination activities through the interdisciplinary care team model, all of which support the complex needs of enrollees regardless of whether the enrollee has physical health or behavioral health conditions or complex SDoH needs. Integration is especially important when one condition or circumstance affects an enrollee's ability to manage other conditions. Our experience demonstrates integration is key to improving outcomes and quality of life for enrollees, which has been confirmed through numerous studies. For example, robust evidence of more than 80 randomized control studies have shown an integrated approach to be the best way to treat depression, including patients with diabetes, cardiovascular disease, cancer, and chronic arthritis. A 2016 retrospective study at the Mayo Clinic found that patients experiencing depression had a significant response to an integrated approach. Those in an integrated program experienced a median time to remission of 86 days compared to 614 days for the group receiving a non-integrated approach.[5]

Behavioral Health and SDoH Assessments

MCOs with integrated care coordination programs are agile in meeting the complex needs of enrollees. This process begins with an integrated approach to assessments. The value of PCPs screening patients for

[5] Garrison, Gregory M., et al., "Time to Remission for Depression with Collaborate Care Management (CCM) in Primary Care," *Journal of the American Board of Family Medicine*, January 2016, 29 (1) 10–17, https://doi.org/10.3122/jabfm.2016.01.150128, accessed August 10, 2020.

behavioral health needs, such as depression, anxiety, post-traumatic stress disorder, and SUD, is supported by numerous studies. Multiple studies show patients are more comfortable disclosing behavioral health needs to their PCP because they are viewed as a partner whose input will continue over time.[6] Further advantages are that the assessment can be administered in a familiar setting and does not need to be duplicated across providers. PCP involvement has been shown to increase patient engagement, which results in a better healthcare experience and improves patient outcomes.[7] To facilitate PCP participation and help promote confidence in PCPs to perform these assessments, programs such as the Oklahoma Department of Mental Health and Substance Abuse Services' (ODMHSAS') partnership with Oklahoma State University Center for Health Sciences for Project ECHO can empower clinicians in rural and underserved communities to provide specialty care to people in the communities where they live and allow specialists to share knowledge across the network of providers.[8]

Molina recommends OHCA require its MCOs to use nationally recognized, evidence-based tools to screen individuals for behavioral health needs (for example, the CAGE-AID for SUD and the PHQ-9 for depression). These standardized assessments ensure a consistent approach to collecting information and ease provider administrative burden caused by multiple assessment forms. It also facilitates population-level analysis for MCOs to assess individual needs and design and implement targeted solutions to address them.

Since behavioral health is so closely tied to SDoH, **Molina recommends OHCA and MCOs collaborate in the development and deployment of standardized screenings for enrollees that include screening for SDoH.** It is estimated just 20% of health outcomes are attributed to clinical care while SDoH account for the remaining 80%. The use of SDoH screenings has been shown to improve providers' ability to understand and act on their patients' needs in their daily lives.[9] **Molina recommends OHCA prioritize selection of MCOs with demonstrated experience conducting SDoH screenings as well as deploying programs and interventions that mitigate enrollees' unmet social needs.** Due to the economic downturn resulting from COVID-19, there may be more individuals who transition from employer-sponsored healthcare coverage to Medicaid. These individuals may be experiencing SDoH hardships that affect their mental health, such as loss of a job, housing instability, food insecurity, or domestic violence, making these screenings even more critical.

Care Planning and Monitoring

Care coordination should be conducted with the MCO as the hub for integration and coordination of providers to deliver seamless support to individuals. These include use of:

- Population-specific care models for a targeted approach to intervention for enrollees experiencing opioid use or SMI
- Joint planning through an interdisciplinary care team from all providers and systems that serve the individual
- Person-centered care plan developed collaboratively, integrated into a single document, and shared among all providers and systems involved in the individual's care
- Tools that allow all participants in the individual's care team secure access to aid in collaborative decision-making

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[6] Shi, Leiyu, "The Impact of Primary Care: A Focused Review," Scientifica, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/, December 31, 2012, accessed August 10, 2020.
[7] Ibid.
[8] Oklahoma Department of Mental Health and Substance Abuse Services, "Evidence-based Services Making a Difference in Oklahoma," https://www.ok.gov/odmhsas/Additional_Information/Agency_Overview/Evidence-Based_Services_Making_A_Difference_In_Oklahoma.html, February 22, 2019, accessed August 10, 2020.
[9] Schuermann Kuhlman, Mary, "Ohio Health Centers Use New Screening Tool to Improve Patient Health," Public News Service, https://www.publicnewsservice.org/2019-07-01/health-issues/ohio-health-centers-use-new-screening-tool-to-improve-patient-health/a66943-1, July 1, 2019, accessed August 10, 2020.

Bidding MCOs should demonstrate their ability to coordinate care across the continuum of risk and severity to meet the needs of the Temporary Assistance for Needy Families (TANF) population as well as populations with more complex needs, such as Aged, Blind, or Disabled (ABD) and long-term services and supports (LTSS) populations, which will ensure a seamless transition of enrollees into SoonerCare.

Using Data for Targeted Care Coordination Efforts

Sharing of data, including screening results, facilitates clinical decision-making across the interdisciplinary care team, which improves the health and well-being of individuals by ensuring they receive the care and services they need to address their whole-person health needs, including behavioral health conditions. Therefore, **Molina recommends OHCA require PCPs to use an authorization form to obtain an individual's consent to releasing PHI to the enrollee's care team.** This process will enhance care coordination by making it easier to share PHI among providers and MCOs securely.

Molina believes the most efficient and secure method to share data is through Oklahoma's health information exchange, MyHealth Access Network. Through MyHealth Access Network, providers can view a comprehensive patient health record that facilitates improved care coordination, reduces unnecessary utilization, and avoids redundant services.

MCOs should have proven capability to support providers by offering additional options for communication and data sharing, such as through a secure provider portal, telephone call center, fax, email, or direct access to their Care Management team.

Support Current Oklahoma Initiatives

We recommend OHCA select MCOs with experience collaborating with state agencies to extend and expand current successful programs and who use a bottom-up approach to community engagement to collaborate around state priorities. One example is the suicide prevention program spearheaded by ODMHSAS. Oklahoma has been effective in moving from the 7th highest in ranking to 16th for suicides.[10] Molina supports ODMHSAS' suicide prevention initiatives and the approach to raising awareness and implementing strategies that expand access to crisis services. MCOs can play a vital role in expanding programs like this partnership by raising awareness and referring providers, community partners, and others to encourage more participation.

Improving Coordination for Members with Chronic and Complex Conditions

How can MCOs improve the management and coordination for members with chronic or complex health conditions?

According to Buffy Heater, chief data, public policy, and promotion officer for the Oklahoma Department of Health, four chronic diseases—cardiovascular disease, cancer, diabetes, and lung disease—account for 65% of all deaths across Oklahoma. Tobacco use, poor diet, and sedentary lifestyle are contributing factors in Oklahomans developing these conditions. In addition to these conditions, our recommendations cover consideration of special populations that include enrollees experiencing SMI, those with comorbidities, individuals with functional needs, and those with complex SDoH needs, such as enrollees experiencing homelessness. Through evidence-based coordination models that are person-centered, holistic, and facilitate access and communication among healthcare and social resources, MCOs play a vital role in improving the lives and health outcomes of enrollees with chronic and complex health

[10] Oklahoma Department of Mental Health and Substance Abuse Services, "Evidence-based Services Making a Difference in Oklahoma," https://www.ok.gov/odmhsas/Additional_Information/Agency_Overview/Evidence-Based_Services_Making_A_Difference_In_Oklahoma.html, February 22, 2019, accessed August 10, 2020.

conditions. Our recommendations below reflect the unique considerations of enrollees with chronic and complex needs and the role of the MCO in improving their health.

To improve coordination of care for enrollees with chronic and complex conditions, we recommend OHCA seek MCOs that can demonstrate:

- **National experience delivering evidence-based programs to a variety of enrollee populations in multiple states.** In support of OHCA's approach to phasing in ABD and LTSS populations, it is crucial that selected MCOs have the expertise to deliver coordination that meets the needs of these enrollees by bringing innovation and best practices
- **Use of evidence-based, person-centered, holistic, integrated models** that identify and engage enrollees, providers, and community-based social services resources to improve outcomes
- **Innovative programs and practices that demonstrate results** such as a transition program between settings of care supporting the enrollee from inpatient admission back to their home
- **Compliant data sharing among providers, enrollees, and social services entities** such as use of interoperable data elements and open systems to facilitate collaboration of enrollees' care and access to social services
- **Flexibility to use resources in the most effective way to achieve results**, such as allowing proprietary, best-in-class stratification processes and skilled care management resources and staffing ratios that meet the needs of individuals served by the MCO
- **True integration of all services, processes, and teams.** Often enrollees with chronic and complex conditions have physical health, behavioral health, functional, and social needs and require a holistic approach to reaching optimal health
- **Proven ability to integrate locally in the community** to meet both enrollee and provider needs. We believe a strong local presence is crucial to meeting enrollees and providers where they are

We detail these recommendations below.

Person-centered Model of Care

We recommend OHCA seek MCOs with demonstrated national experience serving diverse populations with chronic or complex health conditions like those in Oklahoma. MCOs should demonstrate use of evidence-based, person-centered, holistic, integrated models that identify and engage enrollees, providers, and social services resources to improve outcomes. Key elements of the care model should include:

- Use of evidence-based screening tools, provider and community data, and best-in-class predictive analytics to identify enrollees with or at risk of chronic, complex conditions
- Effective, culturally sensitive engagement practices and person-centered care planning
- Integration of health and social services with strong community-based partnerships
- Evidence-based care models proven to improve outcomes for key disease states
- Evidence-based practices that promote transitions to preferred and least restrictive settings of care, which include use of skilled professionals to assist the enrollee, provider, and community partners in achieving enrollee goals. This includes early intervention and engagement of the interdisciplinary care team to facilitate enrollee transitions between settings

Enrollees with complex conditions often have many providers and service providers supporting their care, which can add an additional burden on the enrollee or family. Individuals receiving care coordination / care management should be assigned **a single point of contact**—an MCO care coordinator or care manager—who is responsible for convening care teams based on the individual's specific needs and preferences. The MCO care coordinator or care manager will help the individual adapt to the level and type of support and ensure access to appropriate professionals on the care team. This arrangement ensures enrollees can always call their care manager to help navigate benefits or answer questions directly.

Addressing SDoH. By applying our experience in successfully managing social risk factors, we have found that data is a valuable tool for identifying, assessing, and solving for areas of need. **Molina recommends regular assessments to help identify health and social factors affecting an individual's health status and quality of life.**

Providers also contribute to addressing social needs through activities such as:

- Assessing for social risk factors at the individual level
- Incorporating the results of provider screenings into care management processes
- Deploying interventions for reducing social risk factors at both the community and individual level
- Connecting individuals to a common community resource list

Assessing for health-related social needs should be woven into the care management program as an individual's unique situation may change at any time. For example, an enrollee may have stable housing today but receive an eviction notice tomorrow. Ensuring there is a process to continually update the screening, especially for individuals identified as at risk, is critical and can be done as part of the existing care coordination process. Use of community health workers or other care coordination extenders can be an important part of this process as they work to resolve time-sensitive issues, resolve gaps in care, and connect individuals to community-based services. These strategies, used in combination with other community-based provider approaches, can enhance individual care by supporting providers in identifying and closing care gaps and barriers, sharing information, and facilitating linkages between the healthcare and community-based service systems.

We recommend OHCA MCOs use a comprehensive approach for identifying health-related social needs that may include steps such as:

- Using a health-related social needs screening tool
- OHCA collaboration with MCOs and providers to adopt SDoH billing codes for providers to submit on claims to facilitate identification of enrollee SDoH gaps
- Immediately linking individuals to resources using a system-wide closed-loop referral process to ensure enrollees are able to access the referred service and do not have other needs
- Helping the individual navigate the system of care, and ensuring connection to the MCO through information sharing

Exchanging Data Among Care Coordination Care Team Participants

Just as information sharing is important between providers and the MCO, it is critical to informed clinical decision-making. The ability to address preventive care, drug safety, medication adherence, and potential gaps in the enrollee's care relies on seamless exchange of data between providers, specialists, and enrollees. **We recommend OHCA require MCOs abide by program transparency and accountability standards using real-time, reliable data.** We suggest OHCA convene a workgroup that includes MCOs, providers, and other stakeholders tasked with defining data exchange. MCO and all participants of the care teams must have access to available individual information, and in turn, they must be able to easily share information to facilitate collaboration.

We recommend OHCA consider the following in promoting data sharing and transparency:

- **Consolidating documentation** of all contacts with or about individuals into one electronic care management system that compiles data from external sources and internal episodes of care documentation
- **Promoting interoperability by requiring standard data elements or use of open systems models** to enable MCOs to identify critical risk factors while monitoring and assessing progress toward identified goals
- **Promoting electronic transmission of emergency room and inpatient events** to Medicaid MCOs for early intervention and coordination at the point of service even if the enrollee has primary coverage elsewhere

Through the seamless exchange of health information, providers and MCOs can positively impact safe and prompt individual care. To promote continuity of care between MCOs, OHCA should consider MCOs that can consistently and quickly provide access to or share the following minimum data sets, as applicable:

- Screening, assessment, and care plan information, including health-related social needs data
- Gaps in care data, such as missed EPSDT and health screening appointments
- Immunization data
- Utilization data
- Admission, discharge, transfer data
- Ancillary service data (for example, lab and radiology)

Care Coordination Recommendations

We recommend MCOs be able to use their own data analytics, diagnostics, models and assessment tools to identify and engage enrollees who are considered chronic and complex. Using data and evidence-based screening tools, MCOs should target enrollees for interventions specific to their needs. OHCA and contracted MCOs should identify clinical, behavioral health, functional needs, and SDoH factors specific to the Oklahoma Medicaid membership that may increase the enrollee's likelihood of experiencing hospitalizations, costly medical expenses, institutionalization, or poor health outcomes.

Molina recommends contact frequency and type should be driven by an individual's preferences, acuity level, and needs; influences from SDoH; risk of isolation; and engagement of natural supports. Since these change for individuals as they become more independent or in need of additional assistance, the contact schedule and contact type should be flexible. This flexibility will allow individuals' needs to be met while still fostering a collaborative relationship between the individual, their support system, care manager, and the care coordinator and encourage outreach when needed.

Care coordination is complex and encompasses activities delivered by a wide range of staff, including licensed, certified, paraprofessional, allied health, peer specialist staff, and staff with specific expertise and training (for example, complex physical health conditions, SUD, mental health). Care managers must provide considerable support, training, and technical assistance to effectively coordinate physical health and behavioral health care needs for complex enrollees. As such, OHCA should give MCOs the flexibility to determine and assign the appropriate care coordinator that best meets the individual's needs. For example, a chronically homeless, medically complex enrollee may more effectively engage with a social worker care coordinator who engages registered nurses and medical professionals on the care team.

We recommend OHCA evaluate MCO training programs for cross-training in physical health, behavioral health, and health-related social needs and their level of preparation to help individuals navigate physical health, behavioral health, and social services resources.

Ensuring Enrollee MCO Transitions are Seamless

MCOs have an opportunity to collaborate to develop and implement consistent, timely, and efficient processes to enable more effective transitions. To eliminate duplication of effort, each entity should designate a point of contact for transitions for individuals enrolled in care coordination or care management.

When individuals transition from other MCOs, the receiving MCO's care coordinators should work collaboratively to communicate with the individual, family/caregiver, and their medical and ancillary services teams to provide continuity of care during and after the transition.

We recommend the following efforts to ensure effective MCO care coordination and eliminate care fragmentation and the potential for duplication of services:

- Using **standard elements as part of the care plan and comprehensive assessment** across MCOs, capturing all transition activities and changes in health condition or social situation
- Participating in an interdisciplinary care team whose composition adapts to the changing needs of the individual with a **single point of contact** (the care manager or care coordinator); whenever possible, the care manager or care coordinator should stay with the individual for the duration of their time with an MCO
- **Requiring provider participation in health information exchanges**, such as MyHealth Access Network
- **Consolidating documentation** of all contacts with or about individuals **into one electronic care management system** that compiles data from external sources and internal episodes of care documentation
- Requiring designated Transition of Care staff provide a **discharge assessment** that provides documentation of care and services planned for individuals being discharged from inpatient settings, including post-discharge contacts based on enrollee preferences and needs

Measuring the Effectiveness of the Care Coordination Program

Adoption of nationally recognized, tested, and validated measures that are monitored over time and inform interventions are key to ongoing and sustainable improvement. **Therefore, Molina recommends OHCA:**

- **Continue to rely on measures adopted by leading quality organizations that are relevant for the populations served to measure MCO performance.**
- **Adopt quality of care coordination and care management metrics for all MCOs to ensure alignment.**
- **Select MCOs that can aggregate multiple data sources, such as clinical data, SDoH data, and data collected about enrollees' propensity to engage to design initiatives that support enrollee management of chronic and complex conditions.**

Reducing Barriers to Care and Improving Coordination for Special Populations

What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

We recommend OHCA assess potential MCOs for their expertise and nationwide experience in multiple states serving children in foster care, American Indian / Alaska Native (AI/AN) enrollees, individuals with SMI, justice-involved individuals, and others whose needs present unique considerations. MCOs that work in diverse states bring to bear a depth and breadth of experience that include lessons learned, best practices, and innovations to apply to the SoonerCare mission. With a look to the future of SoonerCare and aligned with our recommended phased approach to transition more complex populations like ABD and LTSS by Year Three, it is imperative that MCOs are assessed on their success serving the diverse needs of all enrollees.

We recommend OHCA gauge the responsiveness and ability of MCOs to serve special populations by ensuring the minimum elements described below:

- **MCOs serving special populations should staff coordinators with experience serving the specific population and be assigned exclusively to serving that population.** The care coordinator engages locally with both enrollees and the providers who serve them. These coordinators should have culturally appropriate experience and training and understand the communities they serve, including the nuances of language, cultural modes of healing, effective outreach strategies, the healthcare landscape as it pertains to the specific population, and connections to strong local partners. This can include understanding how trauma and adverse childhood experiences (ACEs) can impact an enrollee's health and how to interact with enrollees with sensitivity and trauma-informed approaches.
- **MCOs must have experience coordinating with community-based organizations (CBOs), state agencies, and providers** to collaborate along the entire continuum of care. This is especially important with justice-involved individuals and children in foster care as effective coordination requires working with multiple agencies. MCOs often staff those with lived experience who are aware of the barriers these enrollees face; understand how to navigate complex systems to overcome challenges; and know how to motivate the enrollees they serve. For enrollees in foster care, are justice-involved, or who receive services from CBOs, the ability of the MCO to facilitate care and act as the liaison among disparate entities is crucial to meeting the needs of the enrollee and provide a seamless enrollee experience.
- For AI/AN communities, it is important to build relationships and partnerships in the community. Since many AI/AN enrollees receive care from the more than 50 tribal facilities across Oklahoma, the **MCO should be connected to and coordinate well with tribal providers and CBOs, specialty services, and SDoH services that have roots in the community.**
- For foster care enrollees, MCOs should be committed to safe and stable placement of these enrollees and work at the individual level and at the population level to improve care and outcomes. This includes working with families, the judicial system, foster homes, and stakeholders to understand how licensing standards and oversight can be improved, how violations and complaints are dealt with, and effective ways to build the foster care network. MCOs selected for the SoonerCare program should be prepared to use their expertise and experience from other states to apply directly to Oklahoma's service to the foster care population. In coordinating care for these children, **we recommend OHCA assess for an MCO's knowledge and demonstrated strategies to educate providers and others who serve foster kids about ACEs and trauma-informed care**.
- **MCOs should have operational experience collaborating on advisory councils and engaging in stakeholder meetings.** Coordinators who are assigned to special populations often attend stakeholder meetings to understand community priorities, gather feedback, and discuss solutions to address concerns and issues as soon as they become known. Advisory councils are effective in improving quality of care and ensuring the community's priorities and needs are heard and considered in the development of MCO benefits and programs. Bidding MCOs should be able to demonstrate their experience using feedback to bring about meaningful change for their enrollees, providers, and the community.
- To facilitate effective collaboration, **MCOs should have streamlined procedures in communicating and interacting with agencies** that have line-of-site coordination with enrollees in these populations receiving care. MCOs should establish regular communication channels and procedures with relevant agencies. It is important for MCOs to understand the programs available through the state and local health and social service agencies to ensure enrollees are aware of existing programs available to them. By understanding what programs already exist, MCOs can build on the current infrastructure and offer enhanced services that may not be available through these agencies.

Member Services

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
- What tools and resources would help members search for providers? What information should be provided?

A positive enrollee experience often hinges on enrollees having access to clear, easy-to-understand information when they need it. Every enrollee touchpoint is an opportunity to build trust with the enrollee, provide health education, address barriers to care, update and confirm enrollee contact information, or resolve enrollee concerns or complaints. MCOs selected for the SoonerCare program should be prepared to respond to enrollee preferences for how and when they want to receive information with online, offline, and person-to-person options. **We recommend MCOs have demonstratable experience providing Call Center live agent support, an interactive voice response (IVR) system for self-serve options, an enrollee website, mobile app, and use of a variety of mailings for those without online access.** Below, we discuss further recommendations for OHCA when evaluating bidding MCOs for their experience addressing the diverse communication needs of SoonerCare enrollees.

MCO Performance Metrics for Member Services

What metrics should be used to measure MCO performance with regards to member services?

Molina recommends OHCA use industry-standard metrics (such as those found at www.icmi.com) that are quantitative, clearly defined, and therefore, not subject to interpretation. Having a clearly defined standard can facilitate OHCA's comparison of MCOs to one another and their performance overall. The standards and metrics should apply to the MCO as well as any subcontracted vendor performing Call Center operations for the MCO. Metrics should also apply across service teams, including MCOs' Call Centers, Provider Services, the Utilization Management team, or the Care Management team. **Our recommendations are shown in the table below.**

Table 2: Recommended Call Center Performance Metrics

Metric	Recommended Standard
Service Level Agreement (SLA)	80/30 (80% of calls answered within 30 seconds)
Average Speed of Answer	120 seconds
Abandonment Rate	Less than 5%
Blockage Rate*	Less than 1%

Note: **Blockage rate above refers to the policy of restricting the total number of calls concurrently handled in a phone system. Blockage rate can have a false-positive effect on Average Speed of Answer, Abandonment Rate, and SLA when calls are blocked and callers receive a busy signal.*

Our recommendations ensure MCOs have the capacity to handle the volume of calls for the SoonerCare population and no enrollees are turned away or experience delays in their call being answered. Both have a negative impact on customer satisfaction.

We recommend OHCA work with MCOs to implement processes and programs that provide clear indication of customer satisfaction with their Member Services experience. This can be as simple as a member services representative asking the caller if their inquiry was resolved to their satisfaction or using an after-call survey.

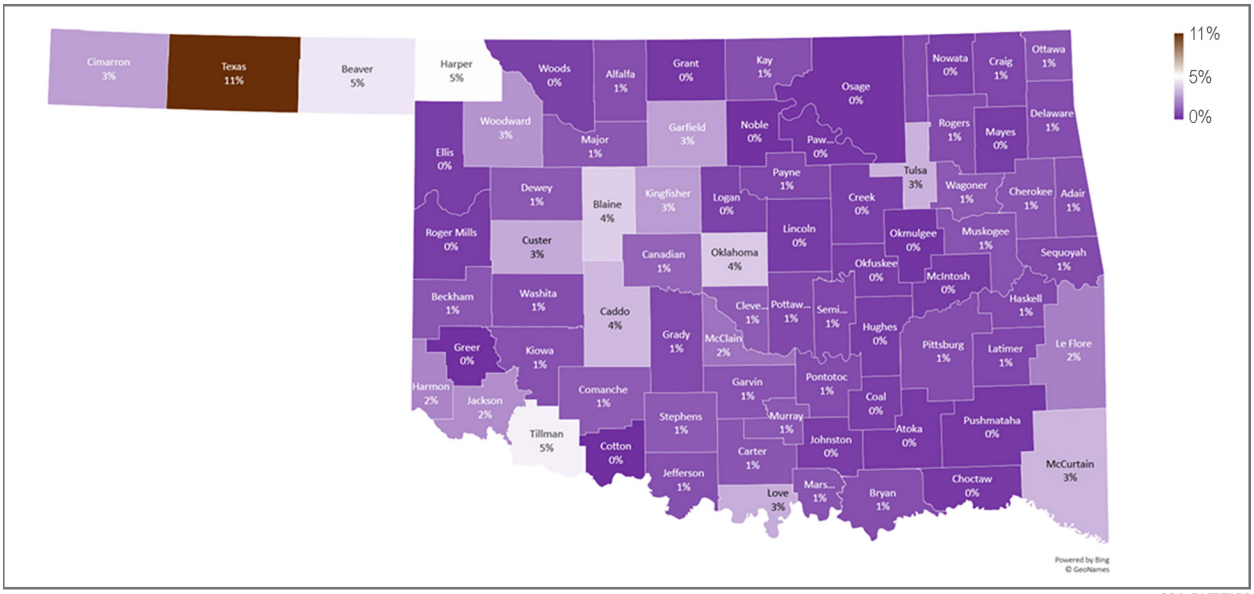
Achieving enrollee satisfaction requires more than having an excellent Call Center. MCOs have a responsibility to make benefit and health plan information and health education and management tools easily accessible and usable for enrollees. MCOs should also provide enrollee materials in simple language; make websites and mobile apps intuitive; and ensure enrollees are provided with a Welcome Kit in which they can find answers to many of their questions.

Communicating with Enrollees

How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

As MCOs serve diverse populations of individuals, it is important for them to implement processes and policies that support effective communication with enrollees. For prevalent languages (like English and Spanish), this includes providing materials in simple language and making bilingual staff, including care coordinators, available to enrollees. **We recommend MCOs train staff on how to access interpretation and translation services and how to offer them to enrollees who need them.** In addition, the enrollee's preferred language should be documented in the enrollee record when it is known to alert staff when interpretation and translation services are needed to facilitate enrollee communication. Exhibit 1 shows that many counties along the Southern border of Oklahoma and in the Northwest portion of the state, such as Texas County, have a high population of non-English speakers. To serve areas like Texas County, where Spanish is prevalent, **we recommend OHCA require MCOs staff bilingual Spanish speakers for enrollee engagement. We also recommend OHCA require MCOs offer a Spanish-language Member Services line.**

Exhibit 1. % Not Proficient in English[11]



001.OKRFI20

[11] American Community Survey (ACS), 5-year estimates (2014-2018).

For other non-prevalent languages, such as Vietnamese and Chinese, **OHCA should evaluate bidding MCOs for their strong community presence and ability to work with local organizations to engage unique populations.** This ability to engage within the local community goes beyond language and includes cultural competency and sensitivity. MCOs should be able to offer additional services through a vendor for interpretation at the site of care (including American Sign Language) or translation of materials. For American Indian/Alaska Native (AI/AN) enrollees, local partnerships with tribal organizations, which can provide resources and expertise in effective communication strategies, translations, and enrollee-level support, are critical to building a relationship with enrollees.

We recommend MCOs be required to produce materials and communications that adhere to the federal government's plain language guidelines. According to the Centers for Disease Control and Prevention, an estimated one in nine adults lack basic literacy skills to understand everyday health information that is routinely available in our healthcare facilities, retail outlets, media, and communities.[12] In Oklahoma, basic literacy is a problem across the state. **OHCA should assess MCOs for their ability to accommodate individuals who do not understand healthcare terminology**. MCOs should produce materials that are easy-to-understand and measured for Reading Ease and Grade Level from an industry-recognized organization such as Flesch-Kincaid. The addition of FAQs, written simply and in conversational language, can spotlight areas enrollees often find confusing.

Finally, we recommend member services representatives be trained in cultural competency and how to accommodate and engage individuals without basic literacy. Often a live conversation is helpful in meeting the enrollee's needs.

Using Technology to Assist Members with Healthcare Needs

How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

We recommend MCOs have, at a minimum, an enrollee website, mobile app, IVR, and Call Center to accommodate enrollees' communication preferences. MCOs should use digital engagement to help enrollees access benefits and manage care at their fingertips. For most commonly performed functions, such as accessing benefits and ID cards to viewing and changing one's primary care provider (PCP), digital technologies allow enrollees to perform self-service healthcare functions on their preferred electronic channel 24/7. Enrollees who can access self-management tools can do so using a mobile app or enrollee website. For example, Oklahomans with diabetes can use capabilities, such as an online health assessment tool, which allows MCOs to identify and engage these enrollees in health education and care management activities.

Communicating with Members without Access to Technology

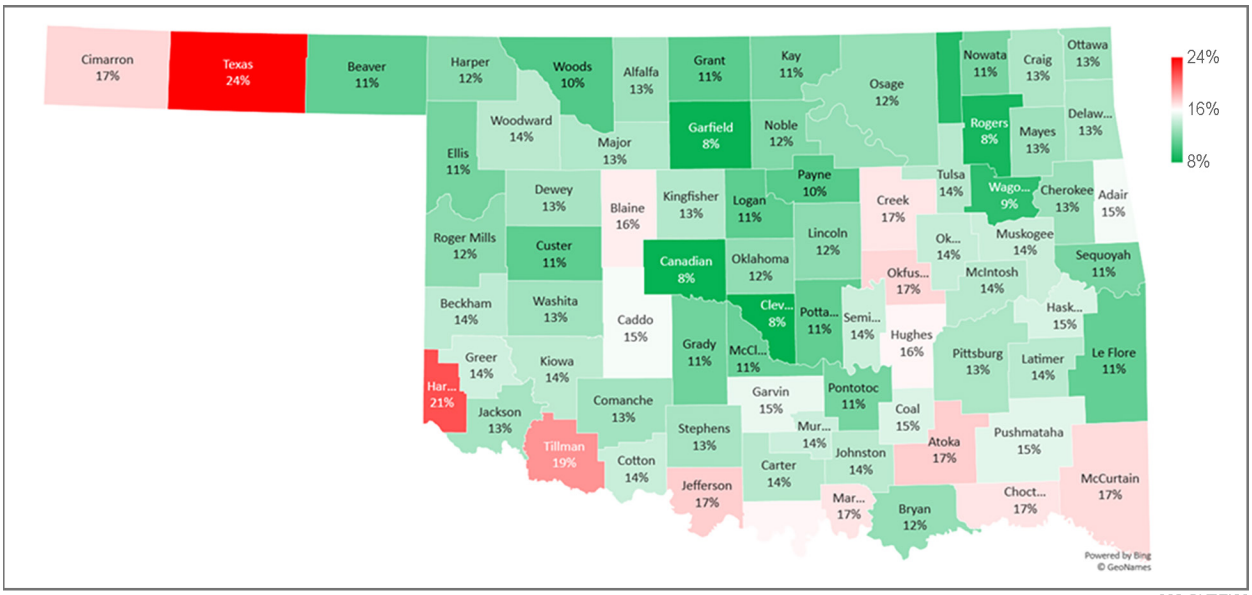
How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

As illustrated in Exhibit 2, Oklahoma faces a connectivity challenge statewide, especially within its low-income population. A 2019 FCC report found that 79% of Oklahoma's population has access to fixed broadband at its speed benchmarks, but those access rates remain highly disparate, with 95% access in urban areas and 48% in rural areas.[13]MCOs must accommodate enrollees with both online and offline options to mitigate these challenges and be willing to bring innovative solutions to the table. **As part of**

[12] "Literacy Fact Sheet: Health Literacy," Oklahoma Department of Libraries, Oklahoma Literary Resource Office, https://www.ok.gov/odmhsas/documents/Literacy%20Fact%20Sheet_%20Literacy%20and%20Health%20-%20Oklahoma%20Department%20of%20Libraries.pdf, December 10, 2012, accessed August 12, 2020.
[13] 2019 Broadband Deployment Report, Federal Communications Commission (FCC), https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf, May 29, 2019, accessed August 14, 2020.

the RFP process, we recommend OHCA request MCOs address access challenges as part of their innovative solutions. Further, OHCA should require MCO participation in a workgroup to explore broadband and technology solutions. The proposal process is an opportunity for OHCA to explore and brainstorm in collaboration with MCOs and the workgroups to expand on the most promising ideas.

Exhibit 2. % with Access to Benchmark Broadband[14]



002.OKRFI20

We recommend OHCA assess MCOs for their capability to provide a comprehensive, multichannel approach to communicating with enrollees using:

- Telephonic outreach for enrollees who prefer to talk with a live agent and do not want to interface with technology
- A 24/7 IVR service that allows enrollees with a telephone to access plan information with self-service options
- On-the-ground teams such as community health workers in support of in-person engagement
- Printed materials mailed to the enrollee's home or available where enrollees receive care and services
- Technology that is intuitive and easy to use with the ability to use some features in an offline mode

We recommend OHCA assess MCOs for their ability to employ staff who understand the community they serve to ensure culturally appropriate face-to-face engagement.

Further, federal programs like SafeLink can provide access to lower cost or free smartphones, but these are often with limited data plans. **We recommend OHCA assess MCOs' ability to supplement the SafeLink program by providing more data, facilitating access to plan information through preprogramming the phone, and installing the MCO's mobile app.** Many enrollees use their phone as the primary way to interact online with the health plan; therefore, this increases the importance of an easy-to-use mobile app experience that allows for access to frequently used information such as ID cards and health records.

[14] Ibid.

Communicating with Members and Receiving Feedback

How can MCOs communicate with members and receive regular input and feedback on program improvements?

We recommend OHCA select MCOs with a regional approach to member advisory committees and offer a "No Wrong Door" approach to receiving feedback. As stated, MCOs need a comprehensive, multichannel approach to receiving feedback from enrollees, regardless of where they live geographically in the state. Enrollees should be provided with multiple opportunities and engagement forums to provide their feedback and voice their concerns, challenges, and barriers to care. **We recommend OHCA request MCOs to demonstrate their ability to respond with solutions that address enrollee challenges.** MCOs should provide a choice to enrollees to respond and communicate with the plan using their preferred method, including online chat, text, email, or by telephone, as well as opportunities for in-person engagement.

Tools and Resources to Help Members Search for Providers

What tools and resources would help members search for providers? What information should be provided?

We recommend OHCA assess MCOs for their provider search capability and the availability of an enrollee web portal and enrollee website and a smartphone app. Enrollees should have multiple and varied ways to find a provider efficiently and easily. MCOs should accommodate enrollees who want to use technology and enrollees who wish to speak to a health plan representative. Provider searches, therefore, should be easy to use and available using a secure, HIPAA-compliant enrollee web portal, enrollee website, and smartphone app. In addition, enrollees should be able to receive a hard copy of the provider directory, make a phone call to Member Services, or ask their care manager for help.

Often, selecting a PCP is a first step to encouraging enrollees to seek preventive care or follow through on attending a wellness visit. **We recommend OHCA evaluate MCOs for their approach to engaging enrollees in selecting their PCP and locating other physicians through a variety of options.** MCOs should conduct enrollee welcome calls immediately following the enrollee's effective enrollment date. During the welcome call, the representative can assist the enrollee in selecting a PCP who matches enrollee preferences for location, languages spoken, cultural needs, and gender. Enrollee touchpoints can also include outbound risk adjustment calls for targeted enrollees who meet specific clinical criteria, which also includes follow up to ensure enrollees went to their appointment. As member services representatives interact with enrollees, they should be trained to ask if they would like assistance in finding a PCP when the enrollee record shows they have not selected one.

We recommend MCOs be required to provide a range of information about providers such as the provider type and specialty, gender, languages spoken, location, hospital and facility affiliation, coverage, and whether they are accepting new patients.

Provider Payments and Services

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?
- What is appropriate for timely payment of claims?
- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?
- How can MCOs best communicate to providers about updates and changes to plan policies?
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?
- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

Molina recommends OHCA use the RFP process to identify MCOs that have extensive government program experience along with a comprehensive provider services approach that has demonstrated success in driving proactive provider engagement, education, collaboration, and transparency; maximizing provider satisfaction and retention; and minimizing provider abrasion.

Metrics to Measure MCO Provider Services Performance

What metrics should be used to measure MCO performance with regards to provider services?

We recommend OHCA require MCOs to record and monitor the following common metrics to measure Provider Services performance:

- **Number of specialists in each health plan's network**
- **Number of behavioral health providers in each health plan's network**
- **Percentage of providers with value-based payment (VBP) arrangements**
- **Call Center data, including provider call volume, patterns, and reported issues**
- **Claims payment timeliness and accuracy**
- **Provider credentialing average turnaround times**
- **Provider voluntary retention metrics**

OHCA should also require MCOs to conduct annual provider satisfaction surveys that measure satisfaction levels with numerous health plan functions and services. For an additional level of input, OHCA should ask providers to confidentially rate MCO performance in a number of activities, including but not limited to, claims processing, providing timely authorizations, responsiveness of provider services representatives, usefulness of communications, network adequacy for referrals, and coordination of care.

Maintaining a Minimum Level of Reimbursement

Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

We **recommend OHCA not maintain a minimum level of provider reimbursement.** While maintaining an adequate provider network is crucial to ensuring SoonerCare enrollees receive the care they need, when and where they need it, through a broad and accessible provider network, in our experience, establishing a minimum reimbursement level typically lowers overall network quality by unintentionally rewarding and retaining poor-performing providers.

To strengthen network quality by rewarding high-performing providers, **we recommend OHCA allow each MCO the flexibility to partner with providers to sustain a level of reimbursement that is tied to quality outcomes and the overall value each provider contributes to the healthcare system.**

Timely Payment of Claims

What is appropriate for timely payment of claims?

Molina recommends OHCA selects MCOs with demonstrated success in meeting the following standards for timely payment of claims:

- **90% of all clean claims paid or denied within 30 calendar days of receipt**
- **99% of all clean claims paid or denied within 60 calendar days of receipt**

We recommend OHCA work with MCOs that offer providers the flexibility to submit their claims with ease, either through a user-friendly provider portal solution, an electronic data interchange (EDI) clearinghouse, or via mailed paper forms. In our experience, working closely with our provider community, EDI-submitted claims ensures the fastest claims receipt and processing. OHCA should also seek MCOs that are willing to support providers with two check runs per week to help ensure timely payments. To further expediate reimbursement, MCOs should offer providers the option to receive electronic remittance advice and electronic funds transfer for payment in lieu of paper checks and remittance advice.

Standardization of Provider Services and Functions

What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

Molina appreciates the critical role providers play in rendering services and expertise in support of the health of individuals throughout Oklahoma. **We recommend OHCA work with MCOs that have experience collaborating with providers on a national level to ensure each MCO can help identify opportunities for standardization that balance administrative ease with program requirements.**

In our experience, the industry has evolved to include some provider services functions that should be standardized across MCOs. **As such, we recommend OHCA require providers to use the Council for Affordable Healthcare's standardized online credentialing application process**, which supports administrative simplification and paper reduction efforts as well as offers the accuracy and integrity provider databases afford.

Table 3 lists other opportunities for standardization OHCA may want to consider and how they can be accomplished.

Table 3. Opportunities for Standardization

Opportunity	How to Accomplish / Recommendations	Potential Barriers to Standardization
Form Standardization	To facilitate prompt processing of standardized prior authorization or concurrent reviews forms, it is essential all the information necessary to evaluate the request is submitted by the provider. Molina recommends OHCA, MCOs, and providers collaborate on ways to improve or modify the current statutory requirements that govern the submission of requests to be considered complete as well as how to implement standardized forms for multiple insurance types.	OHCA should keep in mind that standardization requirements may cause some MCOs to encounter gaps in data and longer administrative turnaround times, which can ultimately lead to provider abrasion. We recommend OHCA require MCOs to collaborate on differences in business practices to identify opportunities for standardization with the fewest barriers to implementation. In our experience, the highest level of success is achieved when MCOs work collaboratively to determine standardization opportunities.
Clinical Decision-making	We recommend OHCA require all MCOs to use American Society of Addiction Medicine criteria to review requests for substance use disorder services.	
Medical Necessity Guidelines	Using evidence-based clinical criteria to confirm medical necessity supports appropriate care and optimal utilization of healthcare resources, and protects individuals' safety. OHCA should contract with MCOs that comply with state and federal guidelines and follow industry-standard, validated care guidelines like InterQual and MCG Health to guide clinical decision-making.	

Provider Communication

How can MCOs best communicate to providers about updates and changes to plan policies?

Molina recommends OHCA require MCOs to offer providers 24/7 access to a secure provider portal and customized website to best communicate with providers regarding updates and changes to health plan policies.

Complementary to the provider portal, **we recommend OHCA require MCOs to maintain a fully HIPAA-compliant provider website, available in English and Spanish, to help direct providers to frequently needed information and resources, including Provider Services, for any real-time support needs.** At a minimum, the provider website should include:

- Online training and webinars covering numerous provider-related topics of interest
- Searchable provider manuals
- Contact information for Member Services, the Nurse Advice Line, and the behavioral health crisis line
- Searchable Provider Online Directory
- Prior authorization criteria as well as current/archived prior authorization codified lists
- Pharmacy preferred drug list and pharmacy conditions for coverage and utilization limits
- Member Rights and Responsibilities, including complaints, appeals, grievances, and the fair hearing process
- "What's New" updates and provider bulletin archives
- Links to other websites such as OHCA and the credentials verification organization(s)
- Link to the provider portal
- Health and wellness materials (including topics on behavioral health)
- Transportation service information
- Premiums and cost sharing, including any conditions and limitations

Helping Providers Navigate Administrative Requirements

How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

A robust provider portal is essential to helping providers navigate plan administrative requirements by connecting them with the self-service tools and data they need to save them time and reduce their overall administrative burden, helping them focus more time on doing what they do best—serving enrollees. **Molina recommends OHCA require MCOs to maintain a provider portal that offers features such as upfront claims submission and validation, and enhanced provider reporting and cost estimation, in addition to other capabilities, such as eligibility and benefits inquiry, authorization/referral, and patient management.**

Additional Provider Services Supports

We recommend OHCA select MCOs that make available Oklahoma-based provider services representatives who are trained and qualified to help providers access a full range of information including eligibility, claims, authorization information, interpreter services, and contracting and credentialing status. Representatives should focus on first-call resolution of provider questions, issues, and concerns or help facilitate a viable resolution.

Helping Providers Participate in Shared Accountability Models

What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

We appreciate that OHCA is focused on strengthening its patient-centered medical home (PCMH) VBP model by building on the existing value-based reimbursement system to improve the relationship between provider quality and payment. **Molina recommends OHCA use the RFP process to evaluate each MCO's demonstrated PCMH experience and success.** This will help ensure OHCA works with MCOs who have the varied experienced in VBP necessary to effectively engage providers in shared accountability opportunities.

During VBP model development, **we recommend OHCA schedule regular face-to-face meetings with key stakeholder groups**, including OHCA, MCOs, and providers. These meetings should be geared toward developing initiatives that support adoption, contribution to, and understanding of the model design.

Following implementation, **we recommend OHCA and MCOs work together to support participating providers through integrated, standardized, and actionable MCO data-sharing and reporting to drive practice transformation and performance improvement, opportunities, and positive evolution of the VBP program.** Accurate, standardized data exchange and reporting also will drive understanding.

In addition, **we recommend OHCA require monthly or quarterly stakeholder meetings as a forum for sharing best practices and lessons learned; reviewing population health data/trends and priorities around which to develop potential new VBP programs; and identifying funding mechanisms to address potential shortfalls**—all to help further increase VBP progress.

Supporting Primary Care Providers (PCPs) in Caring for Their Patients

How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

Molina recommends OHCA use the RFP process to evaluate each MCO's ability to support PCPs with the following:

- Enrollee- and population-specific insights to help providers remain aware of the specific challenges their patients face
- Technology and tools that allow enrollees to engage in self-care and manage their healthcare options in addition to connecting with community-based support services that reduce the overall burden on providers
- Provider-specific training and education on how providers can help reduce their burden with easy-to-use tools such as appointment reminders and tips on reducing barriers to care for enrollees with transportation services needs

Useful Infrastructure, Programs, Training/Coaching

We recommend OHCA work with MCOs who support industry collaboration around provider training and VBP to help drive consistency among provider best practices and enhance the ability of providers to engage with enrollees and participate in VBP arrangements that effectively incentivize provider performance and support improved health outcomes for enrollees.

Molina also recommends OHCA work with MCOs that empower PCPs with the following supports to help them focus on providing the best possible enrollee care:

- Provide regionally based operational support for contracting, credentialing, and authorizations
- Communicate with providers in person, telephonically, and via email
- Offer provider communications and materials specific to the SoonerCare program and system-wide issues
- Escalate systemic or provider-specific concerns to leadership for quick resolution
- Facilitate calls, webinars, and trainings for specific providers, provider types, and regions
- Coordinate with operational departments to streamline processes that contribute to provider administrative burden such as credentialing, prior authorization, and claims submission
- Invite SoonerCare providers to participate in key committees, such as the Provider Advisory Committee and Joint Operating Committee
- Educate providers on how to access quality performance metrics using the provider portal
- Inform the development of alternative payment models and performance-based contracts

In our experience, having dedicated staff with whom providers can connect and have their concerns addressed reliably and timely fosters strong partnerships that lead to provider retention, better enrollee care, and high levels of provider satisfaction.

Network Adequacy

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?
- What are reasonable time and distance standards in Oklahoma by provider type?
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

Ensuring network adequacy must be a joint effort between providers and MCOs. MCOs must be vigilant about the use of appropriate adequacy tracking tools and must clearly define standards of time and distance. As importantly, they must communicate with providers, who often have a better handle on the challenges within a region or population. **Molina recommends the state's RFP promotes a transparent system through which MCOs solicit feedback from providers and provider associations and work together to identify ways to monitor access and availability while minimizing provider burden.**

In addition, **we recommend MCOs be required to demonstrate their intent to deploy a team of Oklahoma-specific, field-based provider services representatives.** A locally based Provider Services team is an essential component of operating an MCO that responds to a state's needs and collaborates with providers and agencies to deliver the highest level of service.

Working with Providers to Meet Access Standards

How should MCOs work with providers to ensure timely access to care standards are met?

Molina recommends OHCA require MCOs to follow NCQA standards for monitoring appointment availability. This ensures providers only need to learn and follow one set of requirements regardless of how many MCOs with which they contract.

MCO monitoring should be an ongoing collaborative effort ensuring a two-way dialogue through which providers can tell MCOs about existing and potential access barriers and work creatively to improve access for enrollees' benefit. For example, MCOs could be encouraged to evaluate adoption of a single, joint survey used by all MCOs to streamline efforts and minimize provider burden.

Although data analysis and geographic information systems are the industry-standard tools to evaluate networks, often there is no substitute for proactively and regularly talking to stakeholders and advocacy groups to identify specific provider types and areas of the state where enrollees are having difficulty getting appointments. They are often the first to know when wait times for an appointment are too long or a provider is not accepting new Medicaid patients. For this effort, field-based provider services representatives are essential.

We recommend the RFP evaluate MCOs on their techniques to monitor and survey providers. These efforts can include independent surveillance by MCOs, Call Center reporting, and tools that each MCO has found effective in its enterprise-wide operations.

American Indian / Alaska Native (AI/AN) Enrollees

Indian Health Service, tribally operated facilities, and Urban Indian Clinics (I/T/Us) are the cornerstone of healthcare for the AI/AN population in Oklahoma. With more than 145,000 AI/AN Medicaid enrollees in Oklahoma, it is imperative for an MCO to work collaboratively with the approximately 50 I/T/Us statewide. **We recommend OHCA seek specifics about an MCO's experience in working with tribal members and facilities to administer services.** In addition to understanding the nuances of the tribal healthcare landscape, MCOs that have operations in bordering states can also represent an advantage to Oklahoma in augmenting network capacity and ensuring access to care for enrollees who travel across

tribal lands that can span multiple states. MCOs that have experience serving in border states may have established relationships with tribal and non-tribal providers that already care for some of Oklahoma's Medicaid enrollees and are in a better position to understand and serve the needs of Oklahoma's AI/AN population.

Tribal healthcare experts and leaders in Oklahoma, such as the Southern Plains Tribal Health Board (SPTHB), should also be an integral part of understanding the health concerns of tribal members in Oklahoma. The SPTHB brings together all 39 federally recognized tribes in Oklahoma as well as tribes in Kansas and Texas to stay informed of the latest healthcare needs and activities. Its tribal epidemiology center serves as a data repository and training and education resource for all matters regarding AI/AN healthcare. Through its quarterly meetings and its regular communications with I/T/Us, the SPTHB can share information about network deficiencies and possible solutions. We understand the Cherokee, Chickasaw, and Choctaw Nations have some of the largest population numbers of all the tribes in Oklahoma with established health systems to provide care for their citizens. It will be important for MCOs to collaborate with these tribal health systems as well as tribal providers that serve and are affiliated with the 36 other tribes across the state to ensure all voices (or tribes) are considered in the delivery of care for the state's AI/AN. **In addition, we recommend OHCA consider MCOs experienced with tribal provider protections under federal and state laws and regulations, as well as cultural preferences and the appropriate supports tribal providers may need to be successful.**

MCOs Assisting Providers with Referrals

One of the greatest frustrations among providers is dealing with the varying forms and procedures of more than one MCO. **Molina recommends all SoonerCare MCOs collaborate to standardize an approach to referrals.** This effort should center on primary care providers (PCPs) and include standardized forms; an online directory that allows for easy navigation of a common list of specialists in each area and within each MCO's network; and contact information for the MCO's Care Management team when the provider needs more assistance in finding a specialist. Most referrals do not require prior authorization, and each MCO's provider manual and provider portal should clearly state criteria for when it is required.

Providers would benefit from the time savings and enhanced information sharing of this approach. Enrollees would benefit because referrals could be targeted based on the enrollee's unique condition and needs instead of the common practice of handing the individual a prescription slip with several provider names written on it. This referral support could be a function under the Care Coordination team, who can assist in identifying and scheduling the appointment.

If MCOs are required to take a more proactive role with referrals, they will be better positioned to monitor and identify areas of inadequate access and need. OHCA will be able to leverage the reporting to measure adequacy of this coordination and access.

To engage specialists for routine and especially for emergent or urgent referrals, the MCO could work with the specialist's office to prioritize the appointment or find a different provider if a timely appointment is not available. A more formalized process would also support specialists if this referral process could track and assist in sharing with the specialist recent clinical or claims information.

Transportation

Molina recommends MCOs administer the SoonerCare non-emergency medical transportation (NEMT) benefit. MCOs and their NEMT brokers have developed shared procedures and requirements nationwide over many years, and they have incorporated technology such as mobile apps to schedule rides and track performance. They have the expertise to guide enrollees to the appropriate transportation option and adjust to the availability of different options in different regions.

In counties with limited access to specialized services, NEMT could help solve distance issues. If an enrollee in one county cannot receive specialized surgery at a local facility, the MCO can coordinate NEMT to a facility farther away that can provide the service. This proactive planning would ensure the enrollee receives the necessary care while avoiding a costly ambulance trip. NEMT can also resolve access issues if an MCO operates in a state bordering Oklahoma and can send enrollees there for in-network services, subject to the out-of-state service policies enacted in 2019. These providers are often closer than the closest available provider within the state.

Reasonable Time and Distance Standards by Provider Type

What are reasonable time and distance standards in Oklahoma by provider type?

In reviewing OHCA's current requirements, we have considered the challenges of meeting time and distance standards in rural parts of Oklahoma, especially those areas without a hospital or behavioral health specialist. **Therefore, we recommend SoonerCare adopt CMS' Medicare time and distance standards as listed in Table 4.**

Table 4. Recommended Oklahoma Access Standards Based on CMS Requirements

	PCP		Specialist	
CMS Classification	Time	Distance	Time	Distance
Metro	15 minutes	10 miles	45 minutes	30 miles
Micro	30 minutes	20 miles	80 minutes	60 miles
Rural	40 minutes	30 miles	90 minutes	75 miles
Counties with Extreme Access Conditions	70 minutes	60 miles	110 minutes	100 miles

The state's current standards for PCP / patient-centered medical home appointments are a provider within 45 miles of an enrollee's residence and appointments within 30 days for routine appointments; three days for non-urgent sick visits; and 24 hours for urgent visits. Although these standards do not account for different geographic considerations, the state may choose to continue with them. **In that case, we recommend time and distance standards apply only in the case of emergent, urgent, and routine care specific to PCPs.** We have found that other states with largely rural geography have experienced difficulties when applying network adequacy standards to too many specialty types and as a result, have had to monitor at the individual specialist level, which creates an additional administrative burden on MCOs and state agencies. It is better to measure the standard more broadly across a group of specialists.

In recognition of the role that telehealth serves to fill gaps in care, traditional time and distance standards may become less important as telehealth grows in prevalence and popularity among both enrollees and providers after the quick expansion during COVID-19. Given the flexibility CMS provides to states under the Final Rule, **Molina recommends OHCA allow for alternative access standards when an MCO can demonstrate it has made reasonable efforts to meet the state's network adequacy standards.** Per 42 CFR §438.68(c)(1)(ix), CMS requires states to consider using telehealth in developing network adequacy standards. **We recommend OHCA consider giving "credit" to Medicaid MCOs for using telehealth providers to meet network adequacy requirements.**

Recruiting More Healthcare Providers to Participate in Medicaid

How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

Persuading hesitant providers to join a network or expand their reach geographically requires a committed effort from MCOs to understand enrollee and provider needs. Our recommendation for an Oklahoma-based team of provider services representatives is based on our experience in building personal

relationships with each provider and giving them an assigned provider services representative as a single point of contact for any questions or concerns.

Reimbursement is typically the foremost of these concerns. Timing of payments can be one of providers' greatest frustrations. This is especially true for practitioners in traditionally underserved and rural communities who operate with much lower budgets and feel the impact of even a small delay. Technology to reduce verification and payment times is essential for any MCO to provide the highest level of provider service. In addition to reimbursements, MCOs can help reduce administrative burden by customizing programs related to authorizations and referrals.

The COVID-19 pandemic hastened the expansion of telehealth, which is now an indispensable tool to treat patients for physical health and behavioral health conditions, and an MCO should be able to demonstrate a proven record of helping providers expand this service. MCO activities could include streamlined authorizations, adjusted reimbursement rates, and communication with providers about important changes such as the CMS update to allow telehealth to be delivered in the patient's home.

In addition to recruiting more providers, **we recommend a focus on recruiting existing providers to offer expanded care, which involves the MCO taking an active role in training and education.** For example, PCPs often treat patients for substance use disorders or a mental health condition that the PCP is not fully trained to address. For those members and providers, Molina offers a higher level of support, including specialized care coordinators.

As another example of recruiting existing providers, areas with shortages are promoting community paramedicine programs, through which emergency medical technicians receive added training and can address routine healthcare needs when a PCP or nurse practitioner is unavailable.

Supporting Healthcare Workforce Development

How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

Workforce shortages within the healthcare system are a widespread issue across Oklahoma and the nation. The State's 2020 Health Professional Shortage Area (HPSA) maps show that of 77 counties, 76 are designated as HPSAs for primary care, 72 for behavioral health care, and 63 for dental care. Shortages in specialty providers, especially pediatric specialists, are particularly acute in Oklahoma.

We believe the best approach to addressing healthcare workforce shortages is a collaborative effort. **We recommend a task force involving** OHCA, MCOs, the Oklahoma Department of Labor, the Oklahoma State Medical Association, the Oklahoma Dental Association, the Oklahoma State Department of Education, Oklahoma Works, and the Oklahoma Health Care Workforce Center. Efforts should focus in particular on the areas identified by the state in its analysis from 2015, as presented in the Oklahoma Health Workforce Data Book, and in continued reporting. Those areas as defined in the request for public feedback are pediatric dentists, pediatric psychiatrists, PCPs, and behavioral health providers.

In addition, we recommend OHCA evaluate MCOs based on their creativity and willingness to form partnerships to address needs. MCOs that have strong relationships with Federally Qualified Health Centers, rural health clinics, and Indian Health Services and other I/T/U providers are in better position to target areas with the greatest unmet needs. Because these facilities are designated as HPSAs, workforce development activities are eligible for federal funding through programs including the National Health Service Corps Loan Repayment and Scholarship Programs, Indian Health Service Scholarship Program, Medicare Physician Bonus Program, and Medicare Surgical Bonus Program.

Other strategies to consider include:

- Allowing healthcare workers to operate at the top of their license or expand the approved healthcare duties in areas of shortage
- Leveraging workforce programming at universities and community colleges throughout the state. For many healthcare disciplines that require only an associate degree and/or certifications, community college represents a lower cost option with a shorter timeframe for completion. MCOs and the state can consider tuition reimbursement. In addition, MCOs can work with community colleges to offer night or flexible classes, as Molina has found through previous work on this issue that class times often conflict with clinical professionals' work schedules
- Engaging the Department of Education and public and private high school counselors to present the full array of healthcare careers, including creating internships with local employers to facilitate interest in healthcare and insurance-related employment
- Identifying and partnering with community-based organizations that have solid programming to address employment as a social determinant of health

Molina recognizes this issue is not specific to Oklahoma and would be willing to share national best practices that are applicable to the Oklahoma market. For example, our Washington affiliate has worked with partners throughout the state to address workforce challenges similar to those Oklahoma faces, including within their AI/AN population. These programs have been successful in engaging educational partnerships, supporting needs of rural providers, and promoting careers in healthcare.

Grievances and Appeals

Questions for Stakeholder Input: Grievances and Appeals
- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?
- How can the state and MCOs use appeals data to improve utilization management and access?

Effective grievances and appeals policies and processes should be an integral part of any healthcare plan to help ensure compliance with the Oklahoma Medicaid False Claims Act. MCOs must approach grievances and appeals in the same way they do quality measurement and the improvement process. As part of a high-quality healthcare program, enrollees must be able to easily file grievances and appeals to address any concerns or dissatisfaction they may have, especially because they can be early indicators of underlying issues.

Receiving Feedback and Addressing Member Concerns

How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

Both MCOs and the state must provide easily accessible channels for enrollees to provide feedback and submit concerns, including submission by mail, email, and verbally by calling the MCO. While some MCOs maintain their grievances and appeals within their Call Center, **we recommend OHCA require MCOs to have a dedicated Grievances and Appeals team to ensure the timely, complete, and successful resolution of enrollees' concerns with the highest level of accountability and to drive improvement**. A dedicated grievance and appeals team is important for successful resolution of issues and to ensure accountability for timely resolution of members' concerns.

In alignment with NCQA accreditation guidelines, we recommend OHCA develop enrollee grievances and appeals requirements that include:

- **Quality of care**
- **Quality of practitioner office site**
- **Billing and financial**
- **Access**
- **Attitude/service**

In addition to having a dedicated team, **we recommend OHCA require a monthly standard report from MCOs**. To assist in decision-making, **we recommend OHCA ask each MCO to submit a sample report as part of the procurement process to assess how each MCO may best meet the state's needs.** Monthly grievances and appeals reports help ensure accountability for addressing enrollee concerns on both the state's and the MCO's part.

Open communication between the MCOs and the regulator further enhances accountability for addressing enrollee concerns. **We support the timelines in OHCA's SoonerCare request for public feedback**, including:

- Answering enrollee questions via telephone or email to resolve grievances and appeals in a timely manner
- Resolving appeals within 30 days for standard requests and within 72 hours for expedited requests
- Resolving grievances in writing within 30 days

Proactive Approaches That Should Be Explored

We agree with OHCA that proactive approaches for receiving feedback and addressing enrollee concerns should be explored. **We recommend OHCA bring all MCOs together in a workgroup to explore and develop consistent approaches for receiving and addressing enrollee concerns.** In Texas and California, all MCOs meet with their respective Medicaid regulators regarding operational issues and trends, which allows for improved communications and systemic change across the programs when needed. Grievances and appeals is an area where MCOs can work together to identify trending issues and develop solutions to directly address the root cause. MCOs should then conduct enrollee experience workgroups, looking at how one system or issue impacts the next. **We recommend OHCA incorporate monitoring activities to assess MCOs' quality improvement processes.** These monitoring activities will ensure grievances are not only being heard, they are being acted upon.

Using Appeals Data to Improve Utilization Management and Access

How can the state and MCOs use appeals data to improve utilization management and access?

Both grievances and appeals data can improve utilization management by identifying:

- Where provider education may be required
- Barriers to care access
- Provider shortages
- Barriers to benefits access

OHCA should select MCOs that can demonstrate how they address issues that warrant further investigation, such as provider access issues or utilization management decisions. By demonstrating how their formal processes use appeals data, OHCA can be assured their MCO partners proactively identify opportunities for improving utilization management and access.

Administrative Requirements

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

As the industry continues to shift to a data-driven, risk-based, and value-based healthcare delivery model, MCOs must work with stakeholders to securely share critical enrollee data to better understand each enrollee's personal healthcare needs. To best serve enrollees at the point of service and throughout the continuum of care, **we recommend OHCA use the RFP process to identify MCOs that are committed to the initiatives we have detailed below, including streamlining data, protecting enrollee privacy, reducing data-sharing barriers, and actively participating in the Oklahoma Health Insurance Marketplace**.

Streamlining Data while Maintaining Appropriate Privacy and Security

How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

To ensure operational efficiency in the sharing of data between MCOs and enrollees, OHCA and MCOs can use the following approaches to streamline data sharing while maintaining appropriate patient privacy and security.

OHCA and MCOs need to consider the variety of data sources and formats needed, and the infrastructure required, to receive and store data in a secure repository. The technology in place must have the ability to normalize, de-duplicate, and aggregate data, as well as provide analytics and insights into each enrollee's holistic health status.

We recommend the state direct MCO partners and key stakeholders, such as health information exchanges (HIEs), primary care practices, and hospital associations, to collaborate and agree upon a standard model of data elements and use HIE as an aggregator to centralize all data with the shared goal of improving both the continuity and continuum of care models. This approach ensures vital enrollee information is available securely and that doctors, nurses, pharmacists, and other healthcare providers have access to the same information at the same time across the continuum of care.

Many Medicaid agencies address privacy concerns around sharing PHI and enrollee data by offering enrollees, as a condition of enrollment, the ability to opt in and opt out of sharing their personal data. Given that OHCA already allows SoonerCare enrollees to opt out of having medical information shared with providers, **we recommend the state establish standards for sharing enrollee information specially protected under federal law (behavioral health data and data for other diagnoses such as sexually transmitted infections, HIV, and genetic conditions) at the point of emergency care.**

At a minimum, we recommend OHCA establish a standardized structure that requires providers and hospitals to share the following data elements to facilitate patient care:

- Demographic information
- Lab results
- Radiology
- Transcripts
- Current medication allergy list
- Encounter diagnosis
- Referring or transitioning provider's contact information

- Pathology
- Immunizations
- Current problem list
- Current medication list
- Procedures
- Discharge instructions (eligible hospitals and Critical Access Hospitals only)

Data-sharing Barriers

What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

Despite the widely acknowledged benefits to be gained by sharing data among the state, MCOs, and providers across the continuum of care, barriers remain. In our experience, the most common barriers to data sharing include the following:

- **Human capital.** For provider groups, rural health clinics, Federally Qualified Health Centers, and those who have limited technical staff, the process of data sharing requires preparation and understanding of associated rules. Extracting and formatting data to the required standards for sharing generally implies the need for additional resource time and effort. In addition, the challenges associated with knowledge about where data exists, how to access data, or the interpretations of HIPAA to make data sharing possible, may require investments in new staff with the right expertise.
- **Lack of technological capabilities.** For providers, technical barriers could include any of the following issues:
  - Data not in electronic form
  - Incompatible or antiquated data formats
  - Incomplete/inaccurate datasets
  - Coding complexities that may take time and additional resources to resolve
  - System interoperability between disparate systems
  - Outdated systems that present challenges for data extraction and/sharing
  - Limited broadband internet connectivity in rural areas
- **Economic cost.** The direct costs of data sharing between MCOs and providers needs to be addressed because data sharing is an expensive proposition. The initial setup and implementation can consume heavy resources depending on the reporting capabilities of the MCO and other partners. Providers may consider an initial trial period or starting with an absolute minimum structure. The Center for Medicare and Medicaid Innovation and the Agency for Healthcare Research and Quality are two of several agencies that offer funds to complete projects that improve care and lower costs.

Overcoming Data-sharing Barriers

Even with limited resources and technology, barriers to data sharing can be overcome with the right approaches to training, incentives, and other collaborative efforts. **We recommend OHCA consider the following approaches to enhance data sharing capabilities:**

Training and development of human resources. Training provider office staff and clinicians is a crucial component of data sharing. OHCA can take advantage of MCOs who can assist by offering best practices, such as creating a group of super users—staff members who are trained to move through data-sharing systems quickly who can share helpful hints, tips, and techniques with other users. In addition, process-based training will help staff understand the new data-sharing workflows.

Incentives. Personal and institutional incentives are often required to prioritize data sharing over other pressing duties. Without the right mix of policy, financial support, and aligned market incentives, MCOs and providers may not be motivated to adopt data-sharing services such as HIE. Furthermore, **we recommend MCOs tie value-based programs to financial incentives and/or penalties to help motivate providers to participate in data sharing.**

Fraud Prevention and Detection Methods

How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

The healthcare industry is in a continual state of modernization and grows ever more reliant on technology; MCOs are no different. **Molina recommends OHCA require MCOs actively monitor fraud hotline tips; use analytics / data mining to detect potential fraud, waste and abuse (FWA); make referrals to law enforcement; and pursue FWA-related recoveries as important functions of their Special Investigations Unit.**

As all instances of fraud and abuse cannot be prevented, it is critical to employ processes that retrospectively detect and address instances that may have already occurred. **Molina recommends OHCA select MCOs with robust capabilities to conduct post-payment reviews** using fraud analytics systems that employ multiple algorithms to identify billing outliers and aberrant service patterns, potential areas of overutilization or underutilization, changes in billing behavior, and possible improper schemes.

Critical considerations are the ability to perform data matching, trending, and statistical analysis to enable peer-to-peer comparisons for cost, service type, and diagnosis type. Also, the state should consider the use of sophisticated models with machine-learning concepts to ensure algorithms are consistently updated.

We also recommend OHCA consider whether MCOs have the ability to assess post-payment data mining and use the outcomes of investigative activities to modify system configurations to prevent further recurrences where possible. These assessments would cover suspected FWA committed by in-network and out-of-network providers, enrollees, caregivers, employees, or other third parties.

Molina also recommends OHCA select MCOs with strong commitments to partnering with industry share groups, state Medicaid and law enforcement agencies, Medicaid Fraud Control Units, investigator forums, and other similar entities to inform their work in driving investigative activity.

We suggest MCOs not rely solely on the above methods. Detection and correction are crucial, but prevention through operational proficiency is the most efficient and effective way to combat FWA.

Prepayment Review Activities

Prevention is the most efficient and effective way to combat FWA. A mature program integrity strategy employs a continuum of activities to address FWA, including internal controls that block FWA events from occurring altogether. Well-run MCOs fully integrate program-integrity-related controls within their operations; therefore, **we recommend OHCA select MCOs that capture the quantifiable results of those controls to better determine the effectiveness of program integrity efforts that support the Oklahoma SoonerCare program.**

MCOs use various prepayment review strategies to avoid the cost of adjudicating erroneous, fraudulent, wasteful, or abusive claims. Cost avoidance may be defined as an intervention that reduces or eliminates an improper payment before the payment is made. Cost avoidance is tangible and quantifiable. MCOs must ensure claims are paid accurately, so OHCA realizes cost avoidance and savings benefits through reduced FWA.

We recommend OHCA partner with MCOs that conduct the following prepayment activities:

- **Claim coding accuracy.** To identify and preempt frequent coding errors and ensure claims are coded appropriately according to Oklahoma and federal coding guidelines, all claims should pass through a multitiered HCPCS/CPT code editing structure powered by expert claims vendors wherein each tier is built upon vendor-specific specialties that vary between tiers.
- **Coordination of benefits.** To block payment of claims submitted with common errors or presenting with potential FWA, automated code reviews should catch issues like unbundling, double billing,

upcoding, and other errors that, according to state and federal billing standards, disqualify a claim for payment.

- **Prepayment reviews.** These reviews should be initiated when an allegation of FWA is substantiated and/or if the financial risk is significant, or upon notification by a regulatory and/or law enforcement agency. This could include reviews based on outlier identification, illogical patterns, complex claims, high-dollar claims, and more.

To accurately coordinate benefits and incorporate the tactics that proactively identify individuals with other insurance coverage as primary in advance of adjudication, **we recommend OHCA require MCOs to quantify and demonstrate the amount of cost avoidance due to these activities by tracking the number of individuals and providers impacted by such programs and by quantifying cost avoidance savings**.

Oklahoma Health Insurance Marketplace Participation

Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

Yes, **Molina recommends OHCA require selected MCOs to offer health plans on the Oklahoma Health Insurance Marketplace no later than January 1, 2023**. This will help ensure continuity of care, particularly for enrollees who fall within the 100–150% federal poverty level population (about 35% of Oklahoma's 2020 Marketplace open enrollment period enrollees) who have a higher likelihood of churning between Medicaid and Marketplace programs as their healthcare needs and eligibility change over time. Requiring Marketplace participation by MCOs will help ensure enrollees maintain access to the care they need when they need it. Due to the changing nature of these enrollees, it is important to bring forward the most experienced MCOs that can support enrollees both in Marketplace and Medicaid, and across those transitions.

Consequently, **we recommend OHCA's RFP consider MCO experience both in Medicaid and Marketplace when identifying MCOs that are best positioned to meet state requirements and serve SoonerCare enrollees.**

The Motivational Incentives Policy Group

July 20, 2020

CLINICAL and COST EFFECTIVENESS OF MOTIVATIONAL INCENTIVES IN SUBSTANCE USE DISORDER

Leadership

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CLINICAL EFFECTIVENESS:

Optimal clinical outcomes can be achieved with Motivational Incentives (also known as Contingency Management) in concert with effective fraud protection through use of the following best practices[1]:

1. Evidence-based practices with research validation
2. Formal protocol implementation
3. Documentation for every patient's care plan
4. Individualized care plans documenting behavioral targets, incentive amounts and schedules
5. For each patient, full, written accounting of every payment, purpose and status of behavioral expectation and actual effort for which the reward is received. For example, documentation should specifically note appointments expected and attended, urine or other substance test expected and whether consistent or inconsistent with medical expectations (i.e., harm reduction, abstinence and/or adherence to prescribed medications).
6. There should be no restrictions based on the percent of patients in a program who may be given monetary incentives at any given time

COST EFFECTIVENESS:

Extensive research shows Motivational Incentives to be the most robust, evidence-based, and cost-effective treatment for stimulant use disorders – which have no known medication treatment. Growing adoption by state and national commercial insurers, state Medicaid agencies, and single state substance abuse authorities, attests to the effectiveness and cost-savings of this intervention.

The Washington State Institute for Public Policy (WSIPP)[2] examined:
1) What works (or does not work) to improve outcomes using meta-analysis,
2) Whether the benefits of a program exceed its costs, and
3) The risk of investing in a program by testing the sensitivity of the results.

RESULTS: Based on an average incentive of $593 per patient over 2-3 months, WSIPP found the following cost-benefit per patient (in 2018 net dollars saved):

Taxpayers	+ $ 3,148	Benefit to cost ratio	$ 39.27
Partients	+ $ 4,060	Benefits minus costs	$ 22,682
Others	+ $ 1,563		
Indirect	+ $ 14,504		

CONCLUSIONS: Incentives have a 77% likelihood of producing benefits greater than their costs. This is for the $100-$200 per month range of financial rewards, which is the reward range that has been found to be most effective.
The benefits of incentives exceeded their costs beginning from the first year.

[1] Knopf, A. (2020). CM, only effective treatment for stimulants, on the ropes as methamphetamine surges. *Alcoholism & Drug Abuse Weekly*, *32*(23), 1–3.

[2] http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/297/Contingency-management-higher-cost-for-substance-use-disorders

COVID-19 Pandemic + SUD Epidemics = Bleak Outlook for U.S. Drug-Related Fatalities

PROBLEM

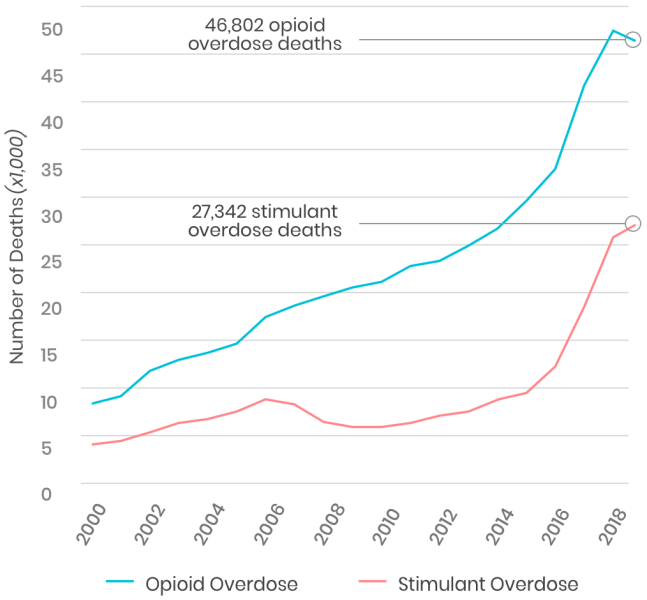
A critically-needed evidence-based practice for effective treatment of stimulant and other addictive disorders is prohibited by the DHHS OIG interpretation of the federal Anti-Kickback Statute. This interpretation deems appropriate motivational incentives to be a violation.

BACKGROUND

The U.S. opioid epidemic still kills thousands each year. In many regions, the next epidemic is already emerging: stimulant-related deaths.[1-4] COVID-19 is expected to make things worse.[5-6]

From 2012-2018, cocaine overdose deaths more than tripled, and deaths involving stimulants (e.g., methamphetamine, cocaine) increased nearly 5-fold.[1] Stimulants were also present in 35% of all opioid overdose deaths in 2018.[2]

Opioid Versus Stimulant Overdose Deaths in the U.S. 2000 to 2018



PROPOSED SOLUTION

A Cost-Effective, Scientific Method for Addictive Disorders: Motivational Incentives

Now more than ever, addiction treatment needs to use motivational incentives. This methodology has been proven safe and effective for opioid and stimulant use disorders.[7] Based on operant conditioning and behavioral economics, it incentivizes abstinence and recovery. Effective for all addiction, it is the best-evidenced and most effective approach in stimulant use disorders.[8-12]

Extensive NIH-funded research shows motivational incentives to be cost effective. Technology makes this scalable, rigorous and affordable.[7] Growing adoption by multiple state and national commercial insurers, as well as interest from state Medicaid agencies and state substance abuse authorities, attests to the effectiveness and cost-savings of this intervention for both populations, including those with co-occurring mental health disorders.[13]

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Motivational Incentives as an intervention for substance use disorder is endorsed by:

World Health Organization

NIH National Institutes of Health

SAMHSA Substance Abuse and Mental Health Services Administration

AAP American Academy of Addiction Psychiatry

ASAM American Society of Addiction Medicine

VA U.S. Department of Veterans Affairs

August 17, 2020

Mr. Kevin Corbett
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (80720200002)

Dear Mr. Corbett:

The National Committee for Quality Assurance (NCQA) appreciates the opportunity to provide feedback on Oklahoma's proposed program design for Medicaid managed care. We strongly support the Oklahoma Health Care Authority (OHCA) in its efforts to drive Medicaid transformation through accountable care. We are especially pleased the proposed program design includes a strong commitment to quality oversight, including use of accreditation. Currently, 31 states require accreditation and 26 accept only NCQA. Our comments focus on the value of using NCQA as the Medicaid accreditor, importance of data integrity, and how Patient-Centered Medical Home (PCMH) principles and goals should remain a foundation for value-based arrangements through inclusion in the managed care organization (MCO) contracts.

Background: NCQA and Oklahoma.

NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. NCQA develops quality standards and performance measures for a broad range of health care entities, including health plans and provider groups. NCQA is deeply committed to working with public agencies to drive improvement in health care and we seek to become a valued managed care quality partner to Oklahoma and OHCA. Currently, Oklahoma uses NCQA programs in the following ways:

- Health Plan Accreditation: NCQA is recognized by the Oklahoma Department of Health as an Independent Quality Examiner (per HMO Act of 2003).

- Performance Measure (HEDIS®[1]): Additionally, OHCA uses HEDIS measures to evaluate the quality of care provided to enrollees of SoonerCare.
- PCMH: In the recent PCMH Redesign, the state proposed recognizing practices with NCQA PCMH Recognition as meeting the state's PCMH standards.

As Oklahoma transitions to managed care, it is helpful to note that NCQA works with state Medicaid programs on quality oversight policy development, including implementing accreditation and incorporating it into the state's Quality Strategy.

Administrative Requirements.

We support the state's intent to incorporate administrative requirements for plans to gain accreditation by a federally approved accreditation body.

Recommendations:

- *Include NCQA's Health Plan Accreditation as a sole accreditation option for MCOs seeking to serve in the state's Medicaid managed care program.*
- *Maximize use of accreditation review by exercising the federal deeming provision in the state's Quality Strategy.*

OHCA can benefit from choosing a sole accreditor and using those reviews to implement the federal deeming provision for enhanced oversight capabilities.

NCQA's Health Plan Accreditation program is the most widely used and respected in the country. More than 169 million Americans—72% of all insured—are in plans accredited by NCQA. Of the twenty-six state Medicaid managed care programs which exclusively require NCQA Health Plan Accreditation, numerous states in the region stand among them (KS, KY, MO, NE, LA, MS, NM, TN).

NCQA Health Plan Accreditation helps plans deliver higher quality care than nonaccredited plans and gives government regulators and health care purchasers the tools to enhance oversight. States rely on NCQA's Health Plan Accreditation for ensuring that plans meet the most current and evidence-based standards.

Benefits of an NCQA exclusive accreditation requirement include:

- *Only Performance-Based Accreditation.* NCQA Health Plan Accreditation evaluates plans by population (Medicaid, Commercial, Medicare and Marketplace) and is the only assessment that scores the quality of clinical care (HEDIS) and patient experience (CAHPS) and requires strict auditing to ensure accuracy. Other programs merely assess whether plans have these critical policies on paper. Performance-based accreditation ensures apples-to-apples comparisons among plans. Requiring a single accreditor, such as NCQA, would assist the state with oversight and management of plans.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- *Oklahoma Carriers Have Experience with NCQA Accreditation.*[2] Six health plans – across commercial, Exchange, and Medicare populations – currently hold NCQA Health Plan accreditation in Oklahoma (including Aetna, Cigna, Medica, and United).[3] We support the state's intent to require Medicaid MCOs to offer health plans on the Oklahoma Health Insurance Marketplace. NCQA accredits approximately 85% of all Exchange plans nationally. If Oklahoma requires accreditation for Medicaid, the state will promote continuity in addressing quality between Medicaid and Marketplace coverage.
- *Supports State and Federal Oversight.* Section 438.360 of the Medicaid Managed Care Final Rule allows states to use information from a Medicare or private accreditation review of plans to provide information for the Medicaid annual external quality review. Maximizing use of accreditation by implementing deeming can significantly reduce department man-hours needed for annual compliance review and allow the state (and EQRO) to reallocate resources for other priority projects. NCQA has tools to aid states through the deeming process and makes accreditation reports for every MCO available directly to states through the my.ncqa.org portal.[4]
- *Provides Transparency Through Public Report Cards and State Access to Accreditation Results.* NCQA publicly reports results on user friendly report cards to promote accountability and help consumers and other purchasers make informed decisions. NCQA Accreditation distinguishes performance through accreditation and performance by product (HMO, HMO/POS, PPO) and product line (commercial, Medicare, Medicaid, Marketplace).
- *Aligns with State Goal to Address Social Determinants of Health.* Population health is a foundational concept of NCQA's Health Plan Accreditation program. Requiring accreditation would assist Oklahoma's goals and plans of promoting population health and addressing social determinants of health. The standards require organizations to outline their population health management (PHM) strategy, including member engagement strategies. Plans also must annually assess the characteristics and needs, including social determinants of health, of its member population.
- *Enhancing the Review to Align with State Priorities.* As NCQA evolves the Health Plan Accreditation program, we have added Distinctions states can add to customize and support state priorities and quality improvement programs. One such Distinction Oklahoma could consider is the Multicultural Health Care Distinction, which focuses on disparities. The Distinction ensures plans are following the culturally and linguistically appropriate services (CLAS) standards. The Pennsylvania Medicaid program requires this Distinction of their plans. The second customization is the MED Module which broadens the array of federally deemable External Quality Review requirements NCQA can review during an accreditation survey. This Module was specifically designed to benefit states as

[2] https://reportcards.ncqa.org/#/health-plans/list?state=Oklahoma
[3] Refer to Appendix A for chart of accredited plans in Oklahoma.
[4] https://www.ncqa.org/public-policy/states/

they implement nonduplication. New Hampshire requires Health Plan Accreditation and the MED Module of all their plans.

Data Integrity Through Audited HEDIS/CAHPS Reporting and Connection with State HIE.

Recommendation: Independent of the NCQA Health Plan Accreditation contract requirement, include contract language requiring MCOs to report audited HEDIS and CAHPS results.

The Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of health care performance measures in the United States. At the federal level, it is required by CMS for Medicare Advantage plans and included in Star Ratings and represents a significant portion of the CMS Medicaid Child and Adult Core Set measures. More than 90% of managed care plans use HEDIS to measure over 90 important dimensions of care and service. NCQA regularly updates HEDIS through a rigorous, multi-stakeholder process to keep up with advances in medical evidence and retires measures that show no room for improvement.

As the state builds their quality goals and priorities around tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes, we can certainly share insight on our measurement efforts supporting these populations. NCQA has a suite of quality measures for these populations covering screening, treatment, care coordination, utilization, and patient reported outcomes. Most recently, we introduced measures addressing alcohol screening and depression screening and a measure to address opioid misuse, which may complement the state's plans.

NCQA Health Plan Accreditation requires plans to undergo a HEDIS Compliance Audit, which allows comparability across organizations and ensures validity and integrity of reported HEDIS data. Plans must also contract with a Certified CAHPS Survey Vendor to administer the CAHPS survey to similarly ensure valid and accurate results. NCQA Health Plan Accreditation requires plans to report HEDIS measures and CAHPS measures as part of accreditation scoring. However, there are additional measures specified for the Medicaid population, which states often rely on for value-based purchasing, federal reporting, public reporting, and/or external quality review activities. Accordingly, it is critical to set the expectation that all HEDIS/CAHPS measures required by OHCA are validated and audited using the same methodology. Key benefits of requiring audited HEDIS/CAHPS results include:

- *Provides Apples-to-Apples Comparison*. The HEDIS Compliance Audit and Certified CAHPS Survey Vendor ensures that plans use a standardized methodology to calculate performance measure and patient experience survey results. If a plan modifies the numerator or denominator in any way (e.g., changes the age band, enrollment period, or exclusions), the measure is no longer considered HEDIS and is not as meaningful since it is not comparable across other plans.
- *Provides Assurances When Payment is Tied to Performance Measure Results.* As indicated earlier, NCQA has many additional measures specified for the Medicaid population. States often use HEDIS measures, both those required for accreditation, as

well as those not required, for value-based payment activities. This is especially important to consider if OHCA considers implementing a Quality Withhold program.

- *Critical for Establishing Benchmarks and External Quality Review (EQR) Reporting.* Often states will use HEDIS/CAHPS measures as part of EQR activities, including Validation of Performance Measures and Validation of Performance Improvement Projects. States can leverage the NCQA HEDIS Compliance Audit Report, provided by the plans, in their EQRO Technical Report. Audited HEDIS/CAHPS results are also critical for establishing benchmarks to inform the Validation of Performance Improvement Projects.

Working with State HIEs. We support a model that includes goals of automatically extracting quality measurement data from electronic health records (EHRs), registries, health information exchanges (HIEs) and other electronic health information (EHI) sources. We believe this reduces reporting burden, improves accuracy of results, and supports more meaningful measures than traditional reporting based on claims data.

We are currently working with the state of New York to pilot a Data Aggregator Validation (DAV) project. The DAV program aims to validate aggregators (e.g., Health Information Exchanges) that collect, aggregate, and transform data from original data sources on behalf of vendors and healthcare organizations. The pilot is looking to demonstrate that aggregators meeting NCQA's standards and protocols have achieved a standard that provides confidence that their data can be leveraged by organizations as standard supplemental data or as abstracted medical records. We know that Oklahoma's existing HIE is sophisticated and seen as a leader in this space. Oklahoma's HIE enables each patient to receive a single comprehensive medical record by being a trusted 3rd party for measurement where payers and providers can contribute their data, and the HIE can do measurement (claims, hybrid, other sources, etc.) in a central way. As the state explores harnessing these important data sources, we urge future consideration of the validation being developed.

Electronic Clinical Data Systems (ECDS). Additionally, NCQA continues to expand our development of HEDIS to leverage electronic data sources. Electronic Clinical Data Systems are a reporting standard for HEDIS and a network of data containing a plan member's personal health information and records of their experiences within the health care system. ECDS measures inspire innovative use of electronic clinical data to document high-quality care. We recommend the state consider requiring plans to use ECDS for HEDIS reporting. Organizations that report ECDS for HEDIS encourage sharing and interoperability of health data systems and ensure that the information needed to provide high-quality services reaches the right people when it is most useful.

Care Management and Coordination

Recommendation: Adopt NCQA Patient-Centered Medical Home (PCMH) Recognition with Behavioral Health Distinction and increased financial incentives tied to recognition as part of the redesign to utilize a value-based strategy that includes integration of behavioral health and social determinants.

NCQA PCMH Recognition is the most widely used way to transform primary care practices into medical homes. Our medical home program focuses on identifying best practices and core activities, signaling that a primary care practice functions as a medical home. The standards promote measurement and improvement at both the clinician and practice level.

As Oklahoma transitions to managed care, NCQA's PCMH recognition program is an excellent way to test provider readiness for value-based payments (VBP) and alternative Payment Models (APMs), while aligning with Oklahoma's vision of better care coordination.

The PCMH model can yield multiple beneficial results. In addition to readiness for VBP, evidence shows it can increase access to care, lower emergency department utilization, improve management of chronic conditions and provision of preventive health care service services.

The value of adding NCQA as an approved accreditor for the state's PCMH program and encouraging MCOs to incent recognition of providers and practices includes:

- *Aligns with State Priorities for Behavioral Health.* NCQA PCMH includes specific evaluation criteria addressing patient-centered access, team-based care, population health management, care coordination, and care management for high risk populations. NCQA PCMH requires practices to meet core criteria, as well as a certain number of elective criteria. States may require specific elective criteria to advance state priorities. Additionally, the NCQA Distinction for Behavioral Health Integration improves treatment of behavioral health and other chronic medical conditions in the primary care setting, resulting in better health outcomes overall.
- *National Recognition Program and Existing Adoption in Oklahoma.* More than 13,000 practices (with more than 60,000 clinicians) are NCQA PCMH recognized – about 18 percent of all primary care clinicians. Twenty-eight public sector medical home initiatives across 24 states require or use NCQA PCMH Recognition. In Oklahoma, more than 372 clinicians across 82 practice sites are NCQA PCMH Recognized.
- *MACRA.* Additionally, NCQA's PCMH Recognition helps providers succeed in the Medicare Access and CHIP Reauthorization Act (MACRA), which is an indication of where federal initiatives will be steered in the future. Clinicians recognized by NCQA PCMH or Patient-Centered Specialty Practices automatically get full credit in the Merit-Based Incentive Payment System (MIPS) within Medicare's new Quality Payment Program. In other words, NCQA-recognized providers also serving Medicare patients may receive higher reimbursement through Medicare. Providers also benefit from Maintenance of Certification (MOC) auto-credit if they are an NCQA PCMH.

Additional Common Interests.

Working with Community-Based Organizations. We were happy to see the state's plan to have MCOs partner with community-based organizations (CBOs) or social services providers. A formal MCO-CBO contractual relationship (i.e. including payment) presents states an opportunity to innovate to address social determinants of health. Aging and disability networks are trusted community level resources serving populations with higher complex needs that often drive a significant proportion of costs and need a medical, social, whole-person approach to care.

CBOs extend person-centered and person-driven care coordination to uncover unmet needs that drive social determinants of health. In the Administration for Community Living *"Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older adults and People with Disabilities,"* addressing SDoH is an important component of high-quality care that reduces unnecessary healthcare utilization. The state of Alabama has worked with NCQA to include the Case Management for Long Term Services and Supports (CM-LTSS) Accreditation as a base requirement for all their Area Agencies on Aging. Despite not having this population in managed care, accreditation is essential for both health plans and CBOs in bridging the collaboration gap and supporting quality-driven reporting related to the impact of CBO service coordination activities on outcomes.

Report Cards. The state technical assistance arm of NCQA offers unique tailor-made assistance to support public sector and private health care leaders in meeting multidimensional challenges. NCQA has extensive experience with quality measure data collection and analysis as well as identification of high performers, quality measure selection, report card/consumer guide development and other technical assistance. We can also produce custom data extracts for the states, including state and regional benchmarks, which can be used as part of state and federal oversight activities, as well as value-based purchasing. NCQA can help build accountability through development and maintenance of report cards, which support transparency and increases engagement. As an example, we work with the New York State Department of Health to produce report cards (consumer guides) and the California Office of the Patient Advocate (OPA) to create provider group report cards. Further, NCQA can lend support as the state thinks through its larger data collection strategy to promote accountability, efficiencies, and innovation.

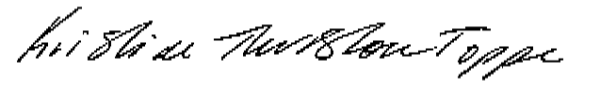
Resources and Next Steps.

NCQA is extremely supportive of Oklahoma's efforts to build a high-performing Medicaid managed care model and look to be a valuable resource as you think through critical quality oversight policies and functions.

We would welcome the opportunity to meet with the state's leadership to discuss these ideas in greater depth. To coordinate, please contact Amy Maciejowski at maciejowski@ncqa.org or 202-735-3688.

We look forward to hearing from you.

Regards,



Kristine Thurston Toppe, MPH

Assistant Vice President, State Affairs

National Committee for Quality Assurance

Appendix A: NCQA Accredited Plans in Oklahoma

(Plans reviewed by population.)

Plan Name	Commercial	Medicare	Exchange
Aetna	✓		
Cigna	✓		
GlobalHealth,Inc.	✓		
Medica Insurance Company-Oklahoma	✓		✓
Sierra Health and Life Insurance Company, Inc.		✓	
United HealthCare	✓	✓	

From: outlook_C3AE84ADBE6E5033@outlook.com
To: OHCA Procurement
Subject: [EXTERNAL] Managed Care Program
Date: Friday, August 7, 2020 10:04:15 AM

To Whom It May Concern:

KI BOIS Area Transit System or KATS provides transportation for twelve counties, taking residents to their medical appointments. People are getting served and it is beneficial to the transit systems being able to use these funds to match Federal dollars.

Don't change something that is working for the people and for rural transit systems.

Thank you,

Charla Sloan, Transit Director
KI BOIS Area Transit System
P.O. Box 727
Stigler, OK 74462

1-800-289-7228

Sent from Mail for Windows 10

From: Laura Corff
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Friday, August 7, 2020 2:05:03 PM

MCO's can improve access by supporting rural facilities.
Medical facilities should coordinate members of long distance non emergency medical transportation from a community or county using scheduling techniques to minimize the one-on-one trips from rural areas to urban areas to keep transportation resources and costs efficient.
Outcome measures: sense of well being, improved quality of life, decreased costs and improved management of chronic health conditions.
Reducing barriers often involves non emergency medical transportation/coordination.

Non emergency medical transportation should be standardized, one broker should be used to maintain the current efficient use and coordination of resources.

Patients should not have to travel more than 50 miles for services unless it is very specialized.

Thanks for your consideration,

Laura A. Corff
Transit Director
United Community Action Program, Inc.
2101 North Fourteenth Street, Suite 129
Ponca City, OK 74601
918-762-3041 Ext. 181
Website: ucapinc.org
lcorff@ucapinc.org

Oklahoma Dental Association

August 17, 2020

Kevin S. Corbett, CEO/Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

Dear Mr. Corbett,

Thank you again to you and your team for taking time to meet with us earlier this month regarding the Governor's desire to convert the state's Medicaid program to managed care. **The Oklahoma Dental Association (ODA) stands firmly opposed to a capitated managed care Medicaid program.** Capitated payments managed by an out-of-state middleman have a long and entirely unsuccessful history in Oklahoma. Such a program is harmful to our patients and our state's health care infrastructure.

As you know, the ODA works to improve Oklahoma's overall oral health, while advocating for the profession of dentistry, the dentists who work within that profession, and the patients they serve. Therefore, in the spirit of advocacy, should Oklahoma's dental Medicaid program be converted to managed care, we do appreciate the opportunity to submit what we feel are the key elements in a managed care Request for Proposal (RFP), as well as the list of best practices for working with dental managed care organizations. The ODA formed a task force to explore what was/was not working in managed care Medicaid states across the country, and from their exhaustive work, the following list of critical points in any managed care RFP was developed:

- There should be a dental "carve out" of Medicaid dental funds whereby the state contracts with a Dental Benefits Manager (DBM) to administer the dental program and reimburses dental providers on a "fee for service" fee schedule as opposed to the dental program being capitated and lumped into the medical managed care program.
- There should be at least one designated ODA representative to provide input during negotiating and structuring of a contract between the state and the DBM(s).
- The first step in the provider audit process should be peer review, completed by a dentist(s) or like-specialist.
- The program should be structured as a non-risk bearing program (ASO) or a partial risk bearing program (hybrid) so that fee cuts are not passed on to the dental providers.
- The provider network should be wide open to all dentists and not a closed panel.
- The program should allow dentists currently enrolled in the Medicaid program to participate in the contractor's network.
- The state should prohibit any requirement for a dentist to enroll exclusively with one contractor.
- The DBM(s) and the state should maintain Medicaid Dental Advisory Committees and the ODA should have representation on such committees.

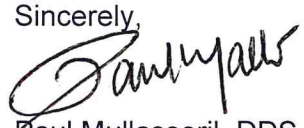
317 NE 13th Street, Oklahoma City, OK 73104 \ 405.848.8873 \ Fax 405.848.8875

- Contracts should be designed so that the state doesn't cede its responsibility for oversight of the health plan(s).
- The state should have a state employee dental director that is an Oklahoma licensed dentist overseeing the health plan(s).
- There should be more than one DBM, creating competition between the DBMs.
- The DBM should provide credentialing and not contract that process to outside organizations.
- The credentialing process should be universal among the DBMs and timely, and provisional credentialing should be allowed.
- Orthodontics, endodontics, etc. should not be limited to specialists, as this severely limits access to care.
- Translation services for providers should be provided free by the state or the DBM(s).
- Nitrous oxide and sedation should be covered at a fair fee.
- A behavior management code should be paid for patients with special needs.
- The number of procedures that must be pre-authorized should be very limited.
- Sealants should be eligible for replacement three years after their initial placement and such service should be reimbursable.
- On molars, a buccal pit filling and an occlusal sealant completed on the same day should be allowable and reimbursable.

In addition to our recommendations from our state task force, please find the attached document listing the best practices when developing a dental managed care RFP, as compiled by the American Dental Association. Keeping in mind the overall health of the citizens of Oklahoma is our primary goal, we can learn from what has worked across the country to ensure a program that removes all barriers to care for those in greatest need.

The ODA appreciates the opportunity to share these recommendations on behalf of our members who are contracted with the OHCA to treat SoonerCare patients and appreciate your earnest consideration. Please feel free to contact our Executive Director, Lynn Means, with any questions.

Sincerely,



Paul Mullasseril, DDS
ODA President

cc: Dr. Mike Herndon, OHCA Chief Medical Officer; Dr. Chris Fagan, ODA President-elect; Dr. Robert Herman, ODA Vice President; Dr. R. Brian Molloy, ODA Dental Care Council Chair; Dr. C. Whitney Yeates, ODA Standing Committee on OHCA Chair and ODA OHCA MAC Representative; and Dr. Karen Luce, OHCA Dental Director

Additional Considerations When Developing an Effective RFP/Dental Contract

Assure Adequate Access

Assuring an adequate network is key to the success of any Medicaid program. Through its contract, the state can assure health equity such that all covered services are as accessible to Medicaid-insured members in terms of timeliness, quantity, duration and scope as the same services are to commercially-covered members in the contractor's region.

- Allow any willing dentist to participate in the contractors' network.
- Allow dentists currently enrolled in the Medicaid program to participate in the contractor's network.
- Prohibit any requirement for a dentist to enroll exclusively with one contractor to provide covered services specifically when there are multiple contractors in a given service area.
- Have written policies and procedures regarding selection and retention of dentists that do not discriminate against dentists who serve high-risk populations.
- Allow enrollees to be able to go out-of-network when specialty services are required if there are no in-network dentists capable/qualified to perform medically necessary services within a reasonable distance/time of where the patient lives. The Medicaid program should reimburse out-of-network dentists in such instances. This is especially important for any child with special needs.

Enrollment and Credentialing

The Medicaid dentist credentialing process is often laborious and time consuming. A state supported common credentialing entity for use across all contractors is ideal. Facilitating a transparent and efficient (online) credentialing process is important for attracting more dentists to a Medicaid program and growing an effective network.

- Adopt standardized criteria and common credentialing entities for credentialing dentists.
- Ensure that all credentialing/re-credentialing applications are processed within thirty (30) calendar days of receipt of a completed application.
- Ensure continuity of care when a dentist is going through the credentialing process (especially for those already participating in the program) when the process takes more than a reasonable time (e.g. 30 calendar days).
- Include an appeals process for dentists not credentialed upon the initial application.

Securing the Dentist-Patient Relationship

Programs should strive to maintain the integrity of the dentist-patient relationship to ultimately achieve high-quality care.

- Ensure enrollees have freedom of choice to change plans and network dentists through a simplified process and without limitations.
- Permit enrollees to obtain covered services from any general or pediatric dentist as the primary care dentist in the contractor's network.

Fee Schedules and Reimbursement

Low reimbursement rates are one of the most significant barriers to dentist participation and beneficiary access. The state should strive to maintain authority in setting the minimum reimbursement rates for covered services.

- Abide by a loss ratio/benefit distribution requirement (annual report). The state should consider establishing a loss ratio/benefit distribution for contracts to maximize the portion of program expense spent for direct delivery of dental services (i.e., dentist reimbursement). Include clauses in the contract seeking reports of administrative expenses versus expenses spent towards clinical care.
- Provide dentists at least 90 days written notification prior to any change in fee schedule or processing policies.

Claims Processing and Appeals

Slow processing and delayed payment serve as a burden to Medicaid dentists. A best practice is to choose a benefits company with dental claims processing experience to manage the dental benefit. Experience with state and federal regulations governing the Medicaid program would also be beneficial. The state can use the contracting process to uphold timeliness and accuracy of payment.

- Abide by metrics for claims processing. Require the contractor to ensure that 95 percent of claims that can be auto-adjudicated are paid within thirty (30) days of receipt of such claims by the contractor/plan administrator.
- Ensure that the remittance advice or other appropriate written notice specifically identifies all information and documentation that is required when a claim is partially or totally denied. Contractors should include details on all errors in the claim submission rather than sending information on only the first noted error.
- Ensure that all prior authorization requests should be handled within 10-14 days for non-emergency and 48 hours for urgent/emergency situations and there should be clearly written policies explaining when such authorization is required.
- Use the services of an Oklahoma-licensed dentist or like-dental specialist who has appropriate clinical expertise/specialty in treating the enrollee's condition or disease when making decisions regarding prior authorization requests or to authorize a service in an amount, duration, or scope that is less than requested.
- Establish an appeals process to review and resolve dentist appeals. Appeals should be resolved within 30 days.

Role of Peers in Resolving Issues

Appointing a dentist as a dedicated resource to manage the clinical aspects of the care provided to a contractor's Medicaid beneficiaries could help ensure the long-term success of the relationship between the contractor and network dentists.

- Employ a dentist licensed in Oklahoma to manage the clinical aspects of the contract such as proper provision of medically necessary covered services for enrollees, monitoring of program integrity, quality, utilization management, utilization review and credentialing processes.

Monitoring Education and Outreach

The onus of improving utilization of Medicaid dental care to improve and maintain oral health through education and outreach lies with both the contractor and the state.

- Have mechanisms to track missed, late and cancelled appointments in order to conduct targeted outreach to members with repeated occurrences.
- Engage in broad outreach and education activities including promoting oral health as part of systemic health and engage families on the importance of achieving good oral health.
- Engage in targeted outreach such as case management for young children with early childhood caries or case management for those individuals with acute or chronic medical conditions.
- Monitor network use and assist members in finding dentists that accept new patients.

Coordination of Care

Evidence indicates that a greater percentage of children are seen in a pediatrician's office than by a dentist especially at younger ages. Additionally, evidence increasingly suggests a correlation between medical and dental conditions for adults. It is important for medical and dental contractors to work together to improve referral and establish dental and medical homes (health homes).

- Work with the primary medical contractor on primary care education and initiatives to improve ease of referral between primary physicians and dentists.
- Establish mechanisms to enable medical-dental coordination for Medicaid beneficiaries, particularly for those individuals with co-morbid conditions.
- Assume responsibility for all members seeking care in the emergency department by establishing an emergency department diversion program, helping to ensure the establishment of a dental home.

Contractor Administrative Performance Monitoring

It is important to assure accountability of the contractor to maintain program standards. To that end, the State's use of performance metrics to monitor the administration of the program will help ensure contractor performance. Contractors and subcontractors should have the capacity to generate analytical reports requested by the state enabling the state to make informed decisions regarding contractor activity, costs and quality.

- Report metrics related to program administration on a quarterly basis which includes:
    - Network size
    - Average time to make payment of claims
    - Accuracy of paid claims
    - Response time (call wait time) in dentist call center
    - Response time (call wait time) in enrollee call center
    - Missed calls in each call center
    - Accuracy of dentist directory
    - Grievance and appeals resolution
    - Credentialing times

- Be accredited by a nationally recognized agency. Such accreditation may assure compliance with minimum standards, aiding the state's oversight efforts to ensure proper administration of the dental program.
- Require contractors to monitor and report patient satisfaction with the plan and its network.
- Require contractors to monitor and report dentist satisfaction through annual assessment of the utilization management and quality improvement programs via network surveys. The state should maintain authority for approving the dentist satisfaction survey tool.

Utilization Management

Compliance with administrative record maintenance rules, program coverage rules, medical necessity rules, state policies, requirements of EPSDT and clinical criteria in the dentist manual are generally monitored through claims audits or random chart reviews. Any issues with compliance relating to claim submissions or contract provisions should be identified in a timely manner to avoid retrospective audits that could jeopardize the network. In addition, payers also evaluate treatment patterns across dentists. Dentists are compared with other Medicaid dentists performing similar procedures based on dentist specialty. Dentists whose treatment utilization patterns deviate significantly (specific standard deviation limit) from their peers are then identified as "under" or "over utilizers". Managing compliance and overutilization must be conducted in a manner that is transparent and fair.

- Allow the state Medicaid dental program director to approve all procedures (including edits in the claims system to assure medical necessity) used to monitor compliance and utilization. At minimum, these policies should detail the processes that will be used to determine "outliers" and applicable benchmarks. It is essential that compliance issues be handled separately from any cases of fraud and abuse and the penalties are structured appropriately.
- Ensure that any audits to determine medical necessity and medical appropriateness of services and treatments are made in consultation with a licensed dentist, who has appropriate clinical expertise/specialty training (same specialty as the treating dentist) in treating the enrollee's condition or disease.
- Have mechanisms to detect underutilization as well as overutilization.
- Provide detailed resources and periodic education and training to dentists and their staffs to inform them about program guidelines and compliance requirements.
- Have readily available mechanisms to resolve disputes by using the ODA's Mediation Review Program, arbitration or another mutually agreeable process as required by federal law.
- Assure that audits are not structured so as to provide incentives for any party to deny, limit or discontinue medically necessary services to any enrollee.
- Allow dentists to have access to an appeal process. Should a dentist decide to appeal an audit finding, no repayment of potential overpayments are to be made until the appeals process returns a final decision on the findings of the audits.
- Ensure that if fraud is suspected, then the case will be monitored by the State and a clear protocol to handle issues should be in place.

Member and Dentist Manuals

Administrative burden for dentists significantly increases if processing policies are unclear or constantly changing.

- Ensure that plans maintain the most up-to-date member handbook (i.e., beneficiary handbook), which among other details includes the summary of benefits, patient copay information, service limitations or exclusions from coverage, member rights and responsibilities, rules for missed and cancelled appointments and details on when the dentist may need prior authorizations.
- Ensure that plans maintain a dentist manual that serves as a source of information to dentists regarding covered services and frequency limitations, a clear definition for medical necessity, contractors policies and procedures for reimbursement (bundling, downcoding, alternative treatment provisions, etc.), dentist credentialing and recredentialing, grievances and appeals process, claim submission requirements, compliance requirements (including those from state statutes), prior authorization requirements, quality improvement programs and dentist incentive programs.
- Ensure that plans maintain a dentist manual that is thorough and up-to-date, rather than referring dentists to additional websites for coverage and processing policies.
- Easy online access to the dentist manual should be provided to all network dentists.
- Provide the manual to dentists before they are asked to sign the contract.
- Ensure timely dentist notification of any specific policy changes by mail or direct electronic communication (in addition to posting on website).
- Provide detailed resources and periodic education and training to dentists and their staff to inform them about processing policies such as prior authorizations that can be significantly different between MCO's and increases the administrative burden for a dentist participating in the program.
- Take responsibility for consistency between the member handbook and the dentist handbook in terms of covered services and processing policies.
- Provide copies of the member and dentist handbook to the state for approval and the state should be notified within 30 days when any changes are made.
- Ensure that enrollees have the ability to easily access the network listing that is most up-to-date. The listing should include information on whether the dentist accepts new patients or not.
- Dentist manuals should have clear language regarding the dentists' rights including but not limited to the following:
    - Obtain information regarding patients' eligibility and claim status in a timely manner.
    - Access to a customer service line with an assurance of minimal wait time to respond to dentist questions.
    - Develop treatment plans needed to bring and maintain patients' oral health.
    - Receive prompt payments on clean claims.
    - Appropriately decline to treat patients who repeatedly miss appointments, are not engaged in maintaining their oral health or are disruptive to other patients in the practice.

- Not be subjected to retroactive decisions based on credential status (e.g., if a dentist is not re-credentialed, any claims already in the system should not be impacted and the dentist should be provided adequate time to refer patients).

Medical Necessity and Processing Policies

When multiple contractors operate in a state and each administers the dental program differently, the enrollees in the state do not receive the same Medicaid benefit. The state should fully define the list of covered services using the most recent version of the CDT Code rather than simply including "EPSDT services" or "dental services" within RFPs and contracts.

- Abide by the state's definition of covered services. Allow the state to review and approve the benefit coverage and contractual limitations regarding coverage and service frequency determinations.
- Allow the state to review and approve the contractors' claims processing policies and policies relating to prior authorizations and claims for medical necessity. It is important for the state to assure consistency in administration of the dental benefit across multiple contractors within the state.
- Have mechanisms in place to check the consistency of application of review criteria by multiple claims reviewers.

August 17, 2020

Oklahoma Health Care Authority

4345 N. Lincoln Blvd

Oklahoma City, OK 73105

Submitted via email: procurement@okhca.org

Re: 80720200002 SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

UnitedHealthcare Community & State appreciates the opportunity offered by the Oklahoma Health Care Authority to provide feedback on the SoonerCare Comprehensive Managed Care Program. We recognize both the importance and the challenges of transforming systems from a fee-for-service platform to one that offers care coordination and integration through managed care and offer the following feedback to OHCA as they undergo this transformation.

We value the State's commitment to stakeholder engagement and look forward to continued collaboration. Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me.

Sincerely,

J. Megan Haddock, Esq.

CEO, UnitedHealthcare Community Plan of Oklahoma

(918) 520-1440

megan_haddock@uhc.com

United Healthcare Community Plan

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

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Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid.
- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting

MCOs will serve members across the state.

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

1) How and when should OHCA transition ABD and other initially excluded individuals to managed care?

The Medicaid population is complex, exhibiting a spectrum of needs that managed care organizations (MCOs) must be able to accommodate to ensure appropriate access and protections for all individuals served by the program. To ensure that OHCA will not face the administrative burden and cost of multiple procurements; to support provider transitions to managed care; to encourage ongoing stakeholder engagement; and to prevent member confusion, we recommend that OHCA release a single procurement, encompassing the needs of the comprehensive population – including Aged, Blind or Disabled (ABD), dual eligibles, and individuals who transition to long term care facilities. This approach will allow OHCA the opportunity to validate the abilities of plans that choose to respond to the procurement and minimize any confusion or legal challenges should OHCA decide to add additional populations in the future to awarded plans. Requiring plans to demonstrate their experience and competency in supporting the needs of the comprehensive population has the added benefit of demonstrating the value of chosen health plans to interested stakeholders.

MCOs wishing to bid should be required to demonstrate specific qualifications and meet certain criteria to prove their capability of adequately caring for both the included and initially excluded populations. Additionally, MCOs should be required to demonstrate readiness to transition initially excluded populations into managed care. OHCA should also require responding plans to provide plans and commitments to proactively engage initially excluded populations to shape the plan's model to address needs and establish an ongoing model to solicit feedback from members, families, providers, and stakeholders.

We offer the following timeline for OHCA to consider transitioning populations into managed care. We believe this timeline will allow more complex members sufficient time to understand managed care and providers adequate time to adjust to managed care and billing changes and OCHA to acclimate to managed care.

Population	Inclusion into Managed Care
TANF & Expansion	Initial implementation
ABD	12 months after initial implementation
LTSS	24 months after initial implementation
I/DD	30 months after initial implementation

2) Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

We caution OHCA in allowing specialty plans as they would likely carve populations too small and would prevent MCOs from achieving sufficient membership mass, compromising program performance. Specialty plans would require OHCA to establish clear plan assignment protocols since many specialties may overlap, and assignment to specialty plans can create unintended incentives to cost shift or transition between plans. Increasing the number of contracts through the procurement of separate vendors for the management of additional populations creates additional system complexity, administrative burden, beneficiary confusion and compromises whole-person care. Minimizing specialty plans would also limit the number of transitions needed for individuals whose status may change, particularly children and youth in foster care.

By structuring the upcoming RFP to assess MCO experience with specialty populations during the managed care procurement, OHCA will be able to restrict the program to qualified MCOs that prove they can manage all populations in order to bid. By only allowing qualified MCOs to bid, OHCA can be confident that all MCOs will be able to meet the needs of all populations.

3) How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

We recognize the vital role members play in managing their health and improving their health outcomes. We welcome opportunities to collaborate with OHCA and key stakeholders to engage members in their health and in wellness activities. Local context and strategies are key components in ensuring the success of any initiative. OHCA, MCOs, and provider partners can deepen wellness initiatives in the state through the following actions:

- **Determine the scope of wellness initiatives and desired objectives:** MCOs should collaborate with OHCA and community partners to set a comprehensive definition of wellness and intended objectives and available supports. Defining wellness in a broad sense accounts for the many components that contribute to a member's well-being. It also standardizes language and efforts across diverse partners, which allows for more comprehensive coordination of effort. For example, chronic conditions are more likely to affect the Medicaid population, and program partners must similarly define the problem and support prevention and management activities. Measurements of success should include effective outreach, engagement levels, and utilization changes related to the intervention.
- **Emphasize education and awareness of initiatives:** Education is an integral part of preventive health and wellness. To engage members, MCOs must raise awareness of the preventive care's effect on overall health and wellness. The utilization of motivational interviewing, activation tools, peer supports, and support groups can help engage members as they interact with care managers, providers, and other touchpoints. MCOs should also raise awareness of the benefits of preventive care and the ability to access care.

- **Adapt wellness programs to meet the unique needs of Medicaid members:** Access, education, immediate/past life circumstances, social issues, and clinical profiles of Medicaid members affect their ability to engage with and benefit from wellness programs. These factors must inform program design by removing barriers to provide appropriate wellness education and programming. MCOs should look for opportunities to engage with community-based organizations (CBOs) and faith-based organizations (FBOs) to promote culturally competent wellness in communities. These collaborations can help make connections to social services and supports that assist Medicaid members in achieving their health and wellness goals.
- **Enhance collaboration between state and local agencies, MCOs, and providers for program efficacy and sustainability:** Utilizing partners that directly engage with members will allow for improved awareness and incentives that are better tailored to specific needs. Program sponsors should consider partnering with agencies such as public health providers, provider organization groups, and state agencies to administer and raise program awareness. MCOs should develop a wraparound culture with partnering practices to reach out to members in need of health care interventions. Efforts should be targeted at meeting members where they are and when they desire to engage in wellness activities. As an example, MCOs can work with CBOs and FBOs to reach members and target interventions. Wherever and whenever members are ready to engage in wellness activities, MCOs and partners should be mobilized and prepared to provide expeditious referrals and support.
- **Establish a streamlined and easily attainable program for members:** Complex or multi-step programs can be cumbersome and be perceived as not worth a members' time. Programs that are clearly defined and are easily attainable are more likely to be adopted. Programs paired with long-term treatment offerings can promote sustainable changes in health and help members participate in long-term solutions rather than short-term behavioral changes.
- **Use Community-based Extenders:** We encourage OHCA to incent MCOs to use Community-based Extenders such as community health representatives (CHRs), community health workers (CHWs), or promotoras, as part of their member engagement strategies. Community-based Extenders can use their local knowledge and networks to outreach to members and coordinate services, including assisting members in making and keeping needed medical and behavioral health appointments, accompanying members to provider appointments, identifying and ensuring fulfillment of post-hospital needs, conducting assessments and health coaching, and providing resources or referrals related to the member's immediate needs. OHCA could further promote the use of Community-based Extenders by providing forums for MCOs to learn from CBOs offering their use, and sharing care management best practices, including best practices around staff training and performance metrics. MCOs should also engage with the Oklahoma Association of CHRs to maintain a vital connection point to these essential Tribal Community-based Extenders.
- **Use of Data Analytics:** MCOs can run sophisticated data analytics based on algorithms derived from evidence-based medicine to identify individuals who are due for routine and specialty medical care. Early identification can be used for proactive outreach by MCO staff and providers, aware of their patients' needs through ongoing data-sharing efforts. Additionally, individual's health opportunities such as the use of tobacco products, out of target range BMI, and the inability to access healthy foods are identified through health risk assessments and engagement with MCO staff, such as care managers in the development of care plans.

Finally, we would like OHCA to consider how we might incentivize and reward members for stepping up to improve their health. Incentivizing innovations could relieve the increasing burden placed on providers to dedicate more time to address the social determinants of health (SDOH) and other barriers faced by members. As an MCO, we would welcome the freedom to test creative ways of incenting members to pursue improved wellness. Incentives might include accessing preventive dental care and transportation via app-based rideshare credits to reduce emergency room visits. MCOs have extensive experience experimenting with models that reward health adherence, especially when there are reliable indicators that paying modestly for health can avoid paying for more expensive health care. Our experience shows the importance of supporting and encouraging individual members' engagement in improving their health status. Without individual engagement, efforts of the state, MCO, and provider will fall short of achieving the Quadruple Aim.

Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure appropriate and sufficient behavioral health care, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in Social Determinants of Health strategies, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers
- Requiring employment of community health workers or other non-traditional health workers

1) What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

UnitedHealthcare supports providers as they work with OHCA to establish fair network adequacy and access standards. We also recognize the need to continue to invest in the health care workforce in Oklahoma to make certain that provider supply meets demand. However, we recognize the shortage of certain specialists in the State, which creates challenges in meeting such standards. OHCA should continue to work collaboratively with providers and MCOs to remove barriers that inhibit access while building capacity through alternative health care delivery models rather than establishing standards that are unattainable and do not materially improve outcomes. These include:

- Improving provider network proximity to where individuals would like to access care
- Offering telehealth/telepsychiatry options
- Integrating medical and behavioral care within care practices
- Creating care options where individuals are most comfortable receiving them (e.g., mobile care vans)

In addition, OHCA should evaluate and remove any unnecessarily burdensome requirements on staffing/licensure that would exacerbate provider availability issues. UnitedHealthcare supports allowing providers to practice at the top of their license. We commend the State for temporarily waiving practice-agreement requirements for nurse practitioners in response to the COVID-19 pandemic. Given the U.S. Health Resources and Services Administration (HRSA) projection that the

State will experience a 26.3% shortage of PCPs by 2025[1], we recommend the State make this change permanent and expand full practice authority to nurse practitioners.

We encourage OHCA to use lessons learned during the COVID-19 pandemic to support providers and MCOs in advancing telehealth capabilities. We would welcome the opportunity to work collaboratively with OHCA to advance and promote telehealth across the State.

2) What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

UnitedHealthcare encourages OHCA to work in tandem with MCOs to optimally support providers in increasing their capacity to focus on care delivery and supporting their transformation towards community-integrated population health management. This includes, but is not limited to, well-informed whole person integration of care, favorably affecting SDOH and measurably improving health outcomes and disparities. MCOs can ease the administrative burden of network providers, reward high performing providers for their commitment to achieving clinical integration and comprehensive population health management and identify opportunities to collaborate more closely in achieving aligned objectives. Provider engagement strategies should consider the full range of providers, including Federally Qualified Health Centers (FQHCs), as they play an important role in promoting targeted population health goals and caring for traditionally underserved populations.

We encourage OHCA to work with MCOs to test innovative payment and delivery system reform initiatives that can further promote patient-centered medical care with a focus on care coordination and management for members. For instance, MCOs can use Community-based Extenders such as CHRs, CHWs, and Promotoras to connect members to PCPs and avoid unnecessary ED utilization. MCOs can use clinical practice consultants and deploy alternative delivery models such as paramedicine and telehealth to further enhance provider capacity and increase access to care. OHCA can also incent MCOs to encourage provider-led clinical-community integration through advanced payment models and data sharing.

To establish integration of behavioral and physical health, MCOs and providers must be able to readily exchange appropriate information, including PHI. OHCA should evaluate and remove any regulatory barriers that inhibit information sharing between MCOs and providers.

3) How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

To achieve a comprehensive and coordinated approach in connecting Oklahomans to services and supports that address and mitigate social determinants of health (SDOH) barriers, OHCA should look to develop a statewide approach that focuses on the following key components:

- **Creation of a standard screen where all providers and CBOs are focused on key state domains and priorities:** OHCA should work with members, providers, CBOs, and MCOs to develop a standardized screening tool to capture priority SDOH elements such housing, food insecurity, employment/educational goals and interpersonal safety in addition to member

[1] U.S. Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf

preferences including self-identified race and gender, primary language, prefer method for receiving communication, and other factors. OHCA can require all providers, MCOs, and CBOs to use this screening tool to enable a shared understanding of a member's most critical social needs and individual care preferences. Improving SDOH data accessibility will allow for appropriate program coordination and linkages across an individual's whole experience. Targeting state resources to bring consistency to SDOH data collection and storage methods across social service programs and enabling the collection of sufficient information will allow testing interventions and predictive analytics to target limited health and social services resources to individuals based upon combined need. Lessons learned from our Hawai'i work with the Accountable Health Communities program, supported by the Center for Medicare and Medicaid Innovation (CMMI) grant, will be valuable resources to support the state in developing screening tools and protocols to best identify and address the needs of our communities and families.

- **Facilitate bidirectional transfer of meaningful, workable data:** OHCA should take an active role in ensuring the sharing of data across MCOs, providers, and, most importantly, CBOs necessary to support connection to needed social services and supports. Greater connectivity has the potential to enhance the maintenance transmission of accurate and comprehensive member data. It allows the entire system to focus and align members' clinical and social needs, including accurate diagnoses, treatment decisions and options, and early identification of inconsistencies, duplications, and failures. These consequences of inadequate data sharing are felt acutely by members and their families, and the burden of untangling becomes an administrative and clinical distraction for providers and MCOs. We recommend OHCA work to enhance the ability to share critical care coordination data (such as screenings, assessments, and care plans) and track social determinants of health, such as North Carolina's NCCare360[2]. Through creating a platform like NCCare360 that allows providers and CBOs to use information from the screen to make connections to local community partners, OHCA can enhance the ability to address or mitigate the identified social barriers. Any approach to data infrastructure development must have active and ongoing engagement from CBOs to be successful.
- **Measurement, Analysis and Investment**: Through the development of both a standardized screen and a resource and referral platform that includes data on "closing the loop" with CBOs providing social services, OHCA, MCOs, providers and CBO partners can use this data, and combined with clinical and utilization data, identify priority areas or domains to be addressed to support goals aimed at improving health and reducing disparities. At a member/population level, MCOs can use data to determine if members are being connected to and receiving services from local CBOs and the impact that has on health utilization. For example, if a child with asthma has a history of ED usage due to household asthma triggers, the State and MCOs can measure if mitigating household triggers has a demonstrative impact on health care utilization. Ongoing evaluation should focus on the utilization and financing effectiveness of addressing the SDOH issue (in this example, mitigating household triggers), and data should be used to drive and influence long-term financing structures and care delivery models. At a community level, this could include identifying areas where demand for

[2] NCCare360. https://nccare360.org/

services is disproportionate to local supply and developing coordinated and aligned investment strategies across payers, providers, CBOs, philanthropy and government to address these disparities. As this system continues to mature and evolve, new opportunities should be explored to broaden Medicaid's reach through the use of waivers to pay for an additional suite of non-clinical social services that lower health care costs by addressing and financing interventions tied to the state and local partners overall goals.

4) How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

UnitedHealthcare supports the administration and reimbursement of behavioral health screening, such as the SBIRT, ACE, PHQ-9, and others, in provider offices. This can be achieved by educating primary care providers, pediatricians, and specialty medical providers on the benefits and availability of these screening resources, what they can do when a screening is positive, and verifying they have the resources and technical support to achieve these efforts. MCOs can help create connectivity across the health care continuum to assist providers in understanding what resources and technical supports are available to them should they not be able to serve an individual with a positive screen.

MCOs, in close contact with OHCA and the Oklahoma Department of Mental Health and Substance Abuse, should work collaboratively to identify brief, psychometrically sound screening tools that collectively promote reimbursement and use. It is critical that any screening tools selected for provider use allow providers choice among the tools for those that best fit their practices and preferences in administration (e.g., AUDIT-C or SASQ for substance use screening). MCOs should verify providers have the resources to conduct the screens consistently, and mechanisms are in place to support timely member referrals if providers need assistance after screening administration and include this content in provider education.

States that have invested in developing a high-quality Medication Assisted Treatment (MAT) network of providers meeting specific criteria have seen substantial increases in the number of MAT providers and utilization. Many of those states have subsequently seen reductions in ED and inpatient visits related to OUD, and some are now starting to see a reduction in overdose deaths. Vermont developed a "Hub and Spoke" model, Pennsylvania developed Centers of Excellence, and Virginia developed a preferred Office-Based Opioid Treatment (OBOT) program. Investing in a network of high-quality MAT providers in primary care practices, EDs, and OBGYN practices could be a critical next step in ensuring treatment capacity across the state. MAT can be expanded through PCPs who want to be trained and become waivered. OHCA could consider tying provider participation to incentive models to further promote the integration of MAT. To encourage universal screening for SUD and treatment initiation, OHCA can also consider linking SBIRT to increasing MAT access in ED/Inpatient settings.

5) What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

Value-added benefits can be a useful tool in allowing MCOs to address the critical needs of a population that otherwise may not be covered These include certain social services related to health inequity and SDOH or innovative programs to modify member behavior through behavioral modification/economics initiatives. We encourage OHCA to allow for the provision of these services, using an approach that supports flexibility. Additionally, MCOs could offer value-added supports to providers through methods such as infrastructure building and continuing education opportunities.

These approaches serve to expand access to care, improve efficiencies in the system through reduced administrative burdens, and decrease provider costs associated with practice management activities.

In addition to value-added services, we encourage OHCA to allow MCOs the flexibility to leverage in-lieu-of benefits to meet member needs. In-lieu-of services (as well as value-added benefits) can facilitate innovative and focused services and solutions, based on individual members' unique needs. If OHCA includes in-lieu-of benefits in SoonerCare, we recommend they be made encounterable services and counted toward the MLR numerator calculation.

However, dental benefits are most efficient when carved into managed care, as opposed to being considered a value-added service. A carve-in dental services model affords an integrated, coordinated and holistic approach to improving the overall quality of oral and physical health care by supporting care across the continuum with a concerted focus on the "whole person." Medical/dental integration fully benefits from the MCO's ability to provide a care delivery system that is connected, aligned, efficient, and capable of delivering high-quality care centered on each member's needs. Should OCHA consider pursing a carve-in dental model, we would be happy to share our experiences in other carve-in markets nationally.

6) How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

For Medicaid members, the lack of reliable and affordable transportation is a real challenge that hinders their ability to get timely and efficient medical care. This could be due to the distance to the provider's location as much as not owning a vehicle or limitations in public transportation. Given the emphasis managed care plans place on preventive care and routine doctor visits, removing transportation challenges is essential to improving health. OHCA should ensure robust Medicaid transportation benefits to help address access gaps. We offer the following recommendations to improve transportation access for the Medicaid population across Oklahoma:

- ***Alternate Modes of Transportation:*** OHCA and MCOs should work together to expand the programmatic use of alternative transportation methods such as mass transit, public transportation, ride-hail services (e.g., Lyft), and mileage reimbursement. These are effective means of transporting non-complex, non-frail members while controlling costs.
- ***Carve-in Non-Emergency Medical Transportation (NEMT):*** As opposed to having it as a value-add benefit, carving in NEMT could help alleviate transportation issues by standardizing the benefit delivery for all members. Promoting access to care through NEMT will help remove barriers that exist with the current value-add program, including removing trip limits, mode of transport restrictions, and prior authorizations. Carving-in would also set standard expectations among the NEMT provider community around safety and credentialing standards, performance thresholds, and program scope. If OHCA regulates a carved-in NEMT benefit, it can be designed with member experience in mind and alleviate some of their top concerns such as:
  - ***Transport Reliability*****:** Create performance guarantees for MCOs to ensure instances of missed trips or untimely pickups/drop-offs are minimized.
  - ***Companions*****:** Allow companions to accompany members (children, siblings, caregivers) to improve the member's ability to schedule and meet medical appointments.

- ***Same Day Transports*:** Allow members to schedule transportation for critical-care appointments at any time, including the same day as the appointment.
- ***Digital Scheduling*:** Require MCOs to offer a digital avenue for members to schedule their appointments.

- **Technology:** While the NEMT industry has the technology available to allow for real-time communication between all associated parties, it has not yet progressed to the point where these technologies are standard. OHCA should encourage or incentivize the use of such technologies to advance MCOs and provider use of such assets.
- **Rural Access:** Rural transit will remain a challenge, especially where public transportation and NEMT providers are less prevalent. Carving-in the NEMT program would give OHCA direct oversight of network adequacy in these areas. In addition, limiting any regulatory or programmatic limitations for telemedicine would significantly improve options for members to connect to medical providers in rural areas.

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes
- MCOs will reimburse providers using a methodology with a performance-based component that incentivizes outcomes for state-priority conditions
- OHCA is investigating the use of incentive measures, quality pools and other programs; MCOs will participate in OHCA efforts to provide enrollees access to quality health care

1) What mechanisms should the state use to incentivize MCOs to improve member outcomes?

OHCA can ensure that MCOs and providers are aligned with shared priorities by identifying the most critical measures of member experience. We recommend that OHCA convene stakeholders, including members, providers, CBOs, and MCOs, to define a small set of meaningful member experience measures. OHCA can hold MCOs accountable for these measures by requiring reporting in the initial years to establish a baseline and then including these measures in MCO quality withholds and/or incentives. MCOs can incorporate these same measures into VBP models to confirm that providers and community partners are motivated and aligned around the same goals.

2) What are the most important indicators of MCO performance? Why?

We encourage OHCA to consider adopting quality benchmarks that measure MCO performance that addresses all services to incentivize whole-person care approaches. We recommend performance measurements be aligned, to the extent possible, across programs and reflect national standards (e.g., National Committee for Quality Assurance or National Quality Forum), wherever possible. The design of performance measures should encourage acceptance by and the participation of the provider community and center on consumer preferences and priorities. Additionally, these measures should be appropriate to the population(s) being served. Important indicators of MCO performance include:

- Member experience satisfaction
- Provider satisfaction and reduced administrative burden
- Timely and accurate claims payment
- Network sufficiency and ability to fill network gaps
- Quality strategy for filling gaps in care
- The Quadruple Aim: Improved Patient Experience, Better Outcomes, Lower Costs, Improved Clinical Experience

These indicators help measure performance from an operational level. Still, OCHA should also measure MCOs on their ability to innovate and create meaningful performance towards making SoonerCare a sustainable, cost-efficient program that improves the health outcomes of Oklahomans.

We encourage OHCA to modernize its Medicaid program by utilizing an auto-assignment algorithm to encourage MCOs to meet quality and efficiency metrics. This approach will ultimately drive value and enhance health outcomes for members while simultaneously improving the financial stability of the Oklahoma Medicaid program. After considering prior health plan enrollment and family affiliation of the health plan, we recommend that OHCA adapt the auto-assignment framework to factor in performance metrics, including quality and efficiency of care. OHCA can then follow the lead of 11 other states which reported using quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) in their auto-assignment algorithms in FY 2019 (according to the Kaiser Family Foundation)[3]. For instance, Hawaii equally distributes membership amongst MCOs for a portion of their algorithm, but the majority is calculated by rating and subsequently weighting MCOs on quality measures such as HEDIS, satisfaction and EPSDT ratios. We encourage OHCA to build off Hawaii's model and include performance measures specific to meeting the State's program goals.

Through intelligent auto-assignment design, such as the Hawaii model, OHCA can fully benefit from MCOs that demonstrate their commitment to meeting the goals established by OHCA. In addition to an alignment of membership to plan performance, the algorithm should ensure equal distribution of high-risk beneficiaries. This helps to avoid adverse selection or participation for an individual plan, which could result in program instability.

We look forward to partnering with OHCA to strengthen the Medicaid program through thoughtful enrollment processes that enhance members' experience and health outcomes while also fostering healthy competition.

3) What measures of health outcomes should be tracked?

Oklahoma's shift to Medicaid managed care provides a unique opportunity to leverage Managed care organizations to improve the health of Oklahomans through partnerships and initiatives that increase accountability through a focus on health outcomes, quality of care and decreased cost. Developing and deploying a comprehensive managed care program that includes behavioral health, pharmacy and dental benefits, provides the best opportunity for Oklahoma to improve health outcomes and care coordination for Oklahoma's Medicaid population. OHCA's focus on whole-person care, value-based models, and addressing unmet needs among its Medicaid population allows for a strong foundation upon which partnerships across the Authority, MCOs, and providers can be built, to improve health outcomes. To adequately address barriers, OHCA will need to put in place additional infrastructure and build partnerships to connect the health care sector in Oklahoma to community-based organizations that support low-income individuals and families.

We support the use of HEDIS® and CAHPS measures for assessing performance around the following areas/domains:

- Improvement in member health
- Member access to care
- Quality and effectiveness of care provided to members

[3] Kaiser Family Foundation. https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-managed-care-initiatives/

- Overall and appropriate utilization of care
- Overall member and provider experience

Use of these metrics aligned with financial incentives and targets, have shown efficacy in improving the health of the Medical populations. Over 75% of Medicaid managed care states currently use chronic disease management metrics when measuring the plan and provider performance. Also, over 50% of states that partner with Medicaid managed care plans use data and outcome measures to monitor critical measurements around perinatal/birth outcomes, core mental health measures such as depression and access to treatment, and EPSDT requirements.

It is critical OHCA consider initially excluded populations, including LTSS and I/DD, when developing quality measures as additional measures are likely needed. Several factors impact which specific quality measures are appropriate when these populations are brought into managed care. OHCA should work with providers, MCOs, and CBOs to evaluate any specific measures that should be tracked for these populations in addition to the baseline framework. Measures should focus on outcomes and identify areas to improve quality of care and member experience for these vulnerable populations.

For Medicaid members with behavioral health conditions, health outcomes that should be tracked include:

- Engagement and satisfaction with treatment
- HEDIS measures particularly for psychotropic medication usage among children
- Inpatient and out of home length of stays
- BMI – for individuals with serious mental illness (SMI) and persons with comorbid behavioral health (BH) conditions
- Diabetes measurements for individuals with SMI
- Psychiatric Inpatient Readmission rate

There are several behavioral health HEDIS® measures that measure the quality of care being rendered. There are also access measures which would include the following:

- **IET:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Care Management and Coordination

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- Conduct health screenings to identify ongoing need, current providers, and social determinants of health
- Develop care plans for identified enrollees and establish care management and care coordination based on identified risk and particular health conditions
- Design health management programs with a holistic approach to member health
- Conduct health education in priority areas and on emerging issues

In addition, MCOs will support Patient Centered Medical Homes under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

1) How can utilization management tools work best for members and providers?

In the transition to Managed Care, utilization management (UM) can be an area of focus and concern for providers. It will be vital for MCOs to work closely with providers and members to inform and educate expectations. The MCO goal should be providing quick, consistent decisions with clear communication to the provider and the member. We recommend that OHCA be flexible in allowing and encouraging digital tools that can include artificial intelligence (AI) to drive timely decisions. The time between claim submission and decision can create issues, but many tools help reduce that time and do it cost-effectively. A key element of that approach will be educating providers on leveraging the technology to make the UM process go smoothly and effectively.

We encourage OHCA to allow and support digital pathways for communication on UM decisions with providers entering information in MCOs' statewide provider portal and the decision response. Keeping this pathway digital can ensure faster turnaround times and lower costs. This approach supports quick, consistent decision making and can facilitate prompt communication to providers and members alike.

Our experience has shown that states with more extensive oversight in medical policy and UM programming, the deployment of policies can be particularly challenging and creates longer wait times and misunderstandings. We encourage OHCA to take a reasonable amount of oversight in this area to harness managed care's value to get the right care at the right time in the right locations.

In UnitedHealthcare's experience, the most effective case management models are those that have sufficient flexibility to maximize MCOs' experience and proprietary tools which have proven ability to identify risk and align resources including case managers, community health workers, peer supports, or behavioral health staff, based on individual needs. In addition, the most efficient programs allow flexibility to develop staffing models that directly align with the needs of the plan's membership.

While well-intentioned, prescriptive oversight requirements – including staff ratios and mandated alignment of staff with specific certification requirements – artificially inflate the program costs and create unnecessarily and unintended inefficiencies. Creating sufficient flexibility allows health plans to apply their suite of analytic tools (e.g., real-time data collection, algorithms, risk stratification) to effectively balance the care management and coordination needs of their specific population. Highly efficient programs can monitor the performance of plans through less arbitrary and prescriptive requirements by monitoring outcomes and other performance metrics. For example, we have extensive experience establishing highly effective care teams capable of stabilizing and reducing utilization costs and improving outcomes for its highest risk members, utilizing proven tools and analytics, to strategically integrate non-traditional health care workers such as Community-based Extenders and peer support specialists (laypersons in recovery from mental illness and/or addition with lived experience using and/or navigating behavioral health care services) into care teams. In some instances, these integral members of the care team may be part of strategic relationships with partners or may be directly employed by the health plan. OHCA must support the continuum from MCO staff to providers to support the beneficiary's relationship with the provider. This approach maximizes the allocation of resources, improves outcomes, and effectively addresses the physical, behavioral, and socioeconomic needs of the population, thereby improving the efficiency of the entire program.

2) How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

Consistency across MCOs in the UM process to reduce administrative burden begins with clear program requirements and benefit design from the State. This supports clarity in coverage and consistency across MCOs. We recommend that the State align with an industry standard UM evidence-based care guideline approach. The State should also streamline the information required for UM decisions across MCOs. This, along with the clarity in program design, will allow MCOs to make quick, consistent UM decisions and clearly explain decisions based on state expectations. This will allow clinicians to discuss potential disagreements within the same framework to understand why decisions are made. We recommend that when UM criteria are established, OHCA sets clear expectations on higher spending service to both MCOs and providers to ensure greater consistency in applying these criteria and if published, will allow providers to understand as they submit a request.

To make certain that utilization management decisions for individuals needing Medication Assisted Therapy (MAT) assume a person-centered approach grounded in assessing the psychosocial needs of the member, we recommend implementing a standardized prior authorization form for higher settings of care, particularly for Residential Treatment Services (ASAM 3.1, 3.3, 3.5, and 3.7) and Inpatient Withdrawal Management (ASAM 4.0). Standardizing this process will limit burden and confusion across providers and will work to strengthen adherence to ASAM guidelines in the provider community and lead to person-centered assessments becoming standardized across all settings of care. ASAM criteria[4] is effective for guiding both utilization management decisions and for network development. Lower levels of care (ASAM levels 0.5 and 1.0) should be accessible

[4] American Society of Addiction Medicine. The ASAM Criteria. https://www.asam.org/resources/the-asam-criteria/about

without authorization. Higher levels of care requiring authorization should be held to timely utilization management decisions that incorporate member needs. Further, care decisions for SUD treatment should align with best practice guidelines issued by the American Psychiatric Association.[5] Utilization management approaches begin with the initial precertification, which is critical to validate proper placement for proper care. Contracting the network to enable immediate access and contractually paying for immediate access is also critical to success.

3) What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

In successful care management models, individuals have a comprehensive delivery system surrounding them that spans across the health care and social environments. Individuals must be well-connected to this broader system. Before the managed care program launch, OHCA should consider a robust communication strategy to educate Medicaid recipients on the program and effectively leverage the broader system – inclusive of the care management benefit. This communication strategy should engage various stakeholders in educating likely program participants. Furthermore, we encourage OHCA to collect accurate contact information for beneficiaries such as cell phone numbers and email addresses at enrollment and recertification and facilitate the flow of that information to MCOs.

As (and after) the managed care program is implemented, MCOs can ensure a smooth transition to managed care as well as broader connectivity to the care system by outreaching to members through innovative methods such as utilizing community health workers, peer supports, and other individuals closely acquainted with local communities and conditions. MCOs also use traditional methods of engagement such as member services, strong care manager relationships, the use of a "welcome letter" or other outreach to identify the care manager and explain the care management benefit.

Understanding the whole person should be at the core of any care approach, especially in Medicaid, with high percentages of dual BH/PH diagnosis. Behavioral health is a part of members' overall health and should be incorporated into a whole health approach to care. This includes a full continuum of mental health and substance use disorder services close to the member's home, care delivery that aligns with members' cultural beliefs and ethnic diversity needs, and care coordination that works with the members where they are both geographically and along their journey of recovery. Care needs to be readily accessible through various modalities, including office-based, telehealth, self-directed and delivered at home.

As OHCA looks for requirements and potential MCO partners, it will be vital to ensure the health plans demonstrate the ability to identify and target priority health needs and members. This is more important than rigorous process-based requirements for health plan engagement. Heavy process measures focused on reporting orients care management to tactics of compliance rather than meaningful member-preference and need backed support. We encourage OHCA to balance reporting and requirements with approaches that MCOs employ to engage with its members, including:

[5] American Psychiatric Association. Clinical Practice Guidelines. https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines

- Having an integrated ID stratification that considers behavioral, medical, social and functional needs
- Having a coordinated team that leverages diverse skill sets and talents to meet members in their care journey - it should be easy for the member

We encourage OHCA to allow MCOs flexibility to leverage a variety of communication channels to engage the member – texting, phone, in-person – based on the acuity of the member need and member preferences. MCOs should have tools to track the communication preferences of members. We would also encourage openness to telehealth solutions that address gaps in access or specialty support.

OHCA should encourage a collaborative relationship with state partners to identify priorities, access gaps and solutions needed to address the evolving and unique needs of the population. This can be achieved through regular care review meetings with health plans that could focus on member engagement.

4) How can MCOs improve the management and coordination for members with chronic or complex health conditions?

The most effective case management models have sufficient flexibility to maximize MCOs' experience and proprietary tools, which have proven ability to identify risk and align resources, including case managers, community health workers, peer supports, or behavioral health staff, based on individual needs. In addition, the most efficient programs allow flexibility to develop staffing models that directly align with the needs of the plan's membership. While well-intentioned, prescriptive oversight requirements – including staff ratios and mandated alignment of staff with specific certification requirements – artificially inflate the program costs and create unnecessarily and unintended inefficiencies. Creating sufficient flexibility allows health plans to apply their suite of analytic tools (e.g., real-time data collection, algorithms, risk stratification) to effectively balance the care management and coordination needs of their specific population. Highly efficient programs can monitor the performance of plans through less arbitrary and prescriptive requirements by monitoring outcomes and other performance metrics.

For example, we have extensive experience establishing highly effective care teams capable of stabilizing and reducing utilization costs and improving outcomes for the highest risk members – utilizing proven tools and analytics – to strategically integrate non-traditional health care workers such as community health works and peer support specialists (laypersons in recovery from mental illness and/or addition with lived experience using and/or navigating behavioral health care services) into care teams. In some instances, these integral members of the care team may be part of strategic relationships with partners or may be directly employed by the health plan. OHCA must support the continuum from MCO staff to providers to support the beneficiary's relationship with the provider. This approach maximizes the allocation of resources, improves outcomes, and is more effective in addressing the physical, behavioral and socioeconomic needs of the population, thereby improving the efficiency of the entire program.

These models also emphasize the need to include community resources. Care Coordination can be a valuable tool in ensuring members with chronic or complex health conditions receive the care they need in the setting they prefer. Strong care coordinators serve as advocates for the member and connect them with the community resources that make the difference. They work to understand the goals of the member. We encourage OHCA to allow MCOs to find "best practice" " innovation that

affords them the ability to primarily focus efforts on individuals with high clinical risk and high complexity combined with impact ability and the propensity to engage in care management who are empaneled – offering the potential for true partnership tailored to collectively tackling the risks/needs of a "community of members."

We recommend that OHCA explore strategies for financing critical SDOH supports through Medicaid and provide flexibility to test innovative partnerships. These include:

- Expanding the use of in-lieu-of-services to finance services
- Flexible contracting requirements that meet the needs of CBOs
- Funding pilots to test which approaches and partnerships are most effective in addressing SDOH
- Applying for an 1115 waiver to enable tenancy supports to be financed within the medical loss ratio (MLR)

In addition, we encourage OHCA to consider the alignment of state funds that support CBOs outside of Medicaid, including value-based payment (VBP) and alternative payment model (APM) arrangements, outside the purview of the clinical model. This alignment of funding would encourage an expanded view of providers (traditional and non-traditional) that can materially improve the outcomes for both individual members and the Medicaid program alike.

5) What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

MCOs should provide training to providers on evidence-based practices on the unique circumstances and prevalent conditions of special populations. MCOs should hire a diverse workforce with expertise in special populations. MCOs must address SDOH factors that hinder special populations from engaging in health care.

As MCOs work with unique populations, access to timely, accurate data is of vital importance. It is important for MCOs to both receive and share data with the State and providers for these individuals. This information can allow all stakeholders to plan an approach for any transitions that need to happen, make informed decisions on care and help the individual meet the goals they have set for themselves.

- ***Foster care:*** It is important to reduce and remove barriers to improve coordination of care for this highly complex population. To ensure this, we believe MCOs should be required to:
  - Have an information technology system where information can be readily shared between the person, caregivers, providers, and MCO care management team
  - Share aggregate data by population with providers, so there is an understanding of the needs the population is experiencing
  - Engage in value-based payment arrangements with primary care physicians to reduce barriers to care for complex populations and rewards providers to coordinate with the person, their caregivers, and their care managers
  - Build a robust network of providers for addressing both the physical health and behavioral health needs for complex populations; this should include incentivizing providers who provide both behavioral and medical care in an integrated setting

- Implement behavioral health home model and use system of care principals to support integrated care for foster families
- Align physical and behavioral health desired outcomes with child welfare permanency goals
- Cover behavioral health family support partners and increase access to specialized providers that are trauma-informed; offer functional-family therapy, multisystemic family therapy, and treat attachment and bonding disorders and adverse childhood experiences (ACE) in very young children
- Promote the use of telehealth and allow psychiatric consults to peer physicians
- Divert child placements from psychiatric residential treatment facilities to home-based, wrap-around services
- Deploy specialized assessments specifically designed for the child welfare and children with SED populations (CASII and CANS); and
- Work with providers to develop value-based program offerings and implement them at a pace that can be absorbed by the providers (usually year 2 and beyond)

- ***AI/AN:*** Members often do not understand they can and should have access to providers and services outside of what is offered through I.H.S/Tribal 638 and other similar entities, including case management. We would recommend to the extent possible that:
  - There be considerations for culturally appropriate native healing options as a covered or value-added benefit to ensure cultural sensitivity in this unique population
  - MCOs should have systems in place to support OHCA in obtaining optimal federal matching for services provided to AI/AN members
  - MCOs hire a Tribal Liaison role who can be on point to help build relationships with tribal organizations
  - MCOs engage early as it is critical to understanding the Tribes/I.H.S/Tribal 638 and other similar entities interests
  - Opportunities and collaboration from a Care Coordination perspective should minimally include – considerations for any current CHR, CM or SW programs – including care team collaboration
- ***Serious Mental Illness (SMI):*** An integrated system of care for adults with SMI should be implemented. It can be aligned with two or more MCOs to ensure that persons with SMI have a choice of MCOs, just like anyone else. Special considerations for this population include:
  - Expand Peer Support to more providers and settings, including hospitals, jails and court-based interventions
  - Require network to have specialized providers for adult members with SMI who have experience with employment and housing services
  - Promote the use of telehealth and allow psychiatric consults to peer physicians
  - Require embedded pharmacy programs to increase medication adherence and care coordination among pharmacists, nurses and physicians
  - Offer specialized services for Native Americans (i.e., White Bison)
  - Provide specialized behavioral health care advocates who can coordinate care bi-directionally

  - Implement a value-based program (year 2 and beyond) for providers who are ready to engage. Provide extensive readiness training for providers and develop data sharing objectives to ensure transparency throughout the program

- ***Criminal Justice Involvement:*** We have had very positive experiences working with this population in several states that we serve, including Washington, Arizona, and Ohio. We recommend that:
  - The State suspend rather than terminate coverage during incarceration to allow MCOs to have more data for an individual as they are released
  - The State facilitate pre-release assignments to MCOs to allow for pre-release planning – providing funding to support, communicate release-date data, share in facility records, focus the MCOs resources on transitions of care
  - MCOs be required to connect with members prior to release to do health assessments, ensure appropriate medications are available for release, make appointments for primary and behavioral health needs, and connect members to community-based organizations for support
- ***Veterans:*** MCOs should designate state to coordinate with Veteran services and support programs to develop a collaborative care team relationship to ensure that our veteran members who are eligible can access all veteran services afforded to them for their service to our country

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- Answer member questions timely via telephone or email and resolve grievances and appeals timely
- Frequently update provider directories online to help members locate health care providers
- Provide member materials in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

1) What metrics should be used to measure MCO performance with regards to member services?

Evaluating performance through member feedback enables MCOs to improve services and simplify the overall member experience. To uphold accountability to our members, we provide opportunities for them to voice their feedback through member satisfaction initiatives. These initiatives include the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, key member indicator (KMI) surveys, our post-call United Experience Survey (UES), and the member portal survey to make sure we understand opportunities for improvement.

We recommend that OHCA standardize what questions members get asked during post-call satisfaction surveys to ensure that MCOs are being evaluated consistently. MCOs should also be granted the flexibility to ask additional questions/collect extra measures at their discretion.

Key metrics that should be measured through post-call surveys include:

- **Service:** Responses help MCOs understand if members are satisfied with the services they receive when they call member services for assistance
- **Call Resolution:** Responses help MCOs discern if the member's issue was resolved to the member's satisfaction
- **Overall Member Satisfaction:** Responses help determine if members are satisfied with the assistance, they have received

In tandem with member satisfaction, HEDIS standard metrics can be used to weigh MCO performance. OHCA could consider setting performance targets and offering MCOs incentives based on HEDIS measures, including:

- Call Service Levels
- Average Speed to Answer
- Abandonment Rate

Ensuring appeals and grievances are handled in a timely and efficient manner is key to providing meaningful and responsive member service. Data should be monitored, including appeals overturn rate, compliance rate, and acknowledgment letter rate, to allow MCOs to maintain high standards, reduce rework of appeals and improve customer service. Tracking complaints and grievances allow MCOs to monitor for needed operational improvements.

2) How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

MCOs should train staff about the cultural needs of members and ways to steer them towards better health. Training addresses the cultural and linguistic characteristics of specific state regions and the

special health care needs of our member population, including the use of interpretive services for effective communication.

MCOs should be able to provide written member materials and telephonic translation services in any requested language. To ensure providers meet the cultural and linguistic needs of members, MCOs can perform an ongoing assessment of their provider networks to make sure providers are adequately meeting Culturally and Linguistically Appropriate Service (CLAS) standards. If small providers and/or providers in rural areas are struggling with offering federally mandated access to interpretation services, MCOs can support providers by offering them access to telephonic interpreters in a variety of languages.

Reading level requirements for member materials are helpful to ensure health care terminology is accessible and understandable. A common practice is to require MCOs to provide member materials that are of 4th-5th grade reading levels. As this may still not make health care terminology entirely understandable, term glossaries can be included on member materials for specific health care terms that cannot be translated to the required reading level. Member Services call centers can also be made available to help members understand terminology.

To build on MCO efforts and best support Oklahomans, we recommend OHCA partner with MCOs who actively engage and partner with CBOs who can leverage CHWs connect and assist members with health literacy and understanding.

3) How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

We support multifaceted communications that make it easier for members to reach us and increase member engagement and personal responsibility. Whether information relates to wellness activities, health care directives, or benefit structure, individuals consume and process information differently. Though entities often consider leveraging technology to enhance or expand communication, they must still recognize that individual needs vary, and communication should meet the needs of the recipient. Thus, the information should be made available through a range of modalities, including hard copy written/illustrative materials and electronic versions, app-based platforms, telephonic, and in-person verbal communication. OHCA should eliminate any regulatory or programmatic limitations on communication modalities, including texting. Enabling individuals to consume information through different modalities will increase the receptivity to what is being shared. When MCOs or providers engage with members, they should identify the member's preference for the method(s) of communication through which they are most comfortable receiving information and work to incorporate that approach into subsequent interactions.

In addition to the modality of information, the mechanism through which it is shared can also increase receptivity. Through the use of widely available, relatively inexpensive technology like text messaging or email, MCOs can engage with members on a wide variety of issues, including immunization reminders, promoting physical activity, motivating engagement in tobacco and alcohol cessation programs, suicide prevention, perinatal care, avoidable use of the ED, and cancer screening. MCOs and providers should consider collaborating on this messaging to generate regionally relevant information that may increase resonance with members. OHCA should collect email addresses and telephone numbers during the Medicaid enrollment process and provide them to MCOs.

4) How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

Mobile phone access for the Medicaid population is relatively high. As it is often their only way to stay connected, Medicaid members often prioritize paying mobile phone bills over other bills. The Pew Research Center conducted surveys between 2013-2019 and identified that 95% of adults in the United States with incomes less than $30,000 have smartphones, with 71% of those surveyed indicating they had a smartphone.[6] The National Center for Education Statistics found that 80.4% of households in Oklahoma had internet access in 2017.[7]

We do know, however, that there are parts of the Medicaid population who does not have access to either mobile devices or connectivity can be less than optimal. To ensure that we can communicate with these members, the State should run data validation on provided addresses during the enrollment process to enable mail and in-person outreach. The State should look to MCOs with processes to leverage community-based organizations and providers to make connections or provide information on behalf of MCOs because these organizations often have more touchpoints with members.

5) How can MCOs communicate with members and receive regular input and feedback on program improvements?

In addition to the post-call surveys mentioned in question 1 of this section, members' invaluable perspectives can be obtained by ensuring that MCOs include members from diverse cultures and backgrounds on Member Advisory Committees and regularly solicit input from the Committee on how providers can foster respect, trust, and empathy. In addition, MCOs can convene focus groups with members from diverse cultural backgrounds and solicit specific feedback on how to improve the delivery of culturally competent care by providers. For example, MCOs can obtain targeted feedback from African American women on how providers can make certain they are treated with respect, trust, and empathy during their pregnancy, birthing experience, and postpartum experience and then incorporate this feedback into quality improvement initiatives and VBP models focused at decreasing maternal morbidity and mortality for women of color. We recommend Member Advisory Committees be cross sectional and include community groups and providers. Having representation from partners will allow them to hear member input and make collaboration easier to remove member barriers and make programmatic improvements.

A robust grievances and appeal process can also be a useful source for MCOs to receive input and feedback from members.

[6] https://www.pewresearch.org/internet/fact-sheet/mobile/

[7] https://nces.ed.gov/programs/digest/d18/tables/dt18_702.60.asp?current=yes

6) What tools and resources would help members search for providers? What information should be provided?

MCOs should provide an online provider search tool that is available to both existing members and prospective members. Online directories can be updated in real time to ensure accurate information is being provided. A printed provider directory in any language should be provided upon request. All our new members receive a welcome call to educate them on the tools and resources available. Members can also contact Member Services for assistance locating a provider in their area or scheduling an appointment.

Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

1) What metrics should be used to measure MCO performance with regards to provider services?

We recognize the importance of supporting the providers in our network. It will be very important as the State transitions to managed care that providers feel confident in their ability to communicate with managed care organizations and that managed care organizations establish patterns that will work for all providers in the state. We recommend that OHCA establish requirements for multiple modes of communication so that providers can pick the right way to communicate with MCOs no matter the topic. Further we recommend that OHCA establish requirements that a portion of provider services staff be local. Some metrics that OHCA could use to measure performance are:

- Answer times for provider services call center
- Hold times for the call center
- Call abandonment rate
- Credentialing time and accuracy
- Provider complaints
- Claims payment accuracy and timeliness
- Timely appointments
- Provider satisfaction survey results
- Provider appeals time to resolution
- Provider interactions with MCOs via their provider portal and any written correspondence

During implementation, we also recommend that OHCA track provider education and training. This could be accomplished via reporting on the number of events held, the number of providers trained, the number of self-paced training events and other metrics that show how MCOs are endeavoring to make the transition to managed care.

One area that will help with a smoother transition to managed care as well as provider support on an ongoing basis is a standardized credentialing approach for all MCOs. A common complaint we have heard from many providers in other states, is that the credentialing process is challenging to go through for each managed care organization as they join their network. We recommend that OHCA consider implementing an approach where providers would only have to use one approach to be credentialed for any MCO network in which they choose to participate. This process could be led by OHCA or MCOs selected for the contract could propose and approach to OHCA.

2) Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

Based on our experience in serving nearly 6 million members in over 31 states and the District of Colombia, we recommend that any minimum reimbursement rate should be developed to encourage participation in managed care networks and be established in relation to the fee-for-service (FFS) reimbursement rate that is published by the State. To support the State in managing taxpayer dollars, overall risk for Medicaid members and the Medicaid program, while encouraging the development of robust networks, we recommend that OHCA include language in the program that MCOs may reimburse providers who choose to not participate in an MCO's network – following three valid attempts to contract – be paid at 90% of the FFS published rate. This policy level will support the development of robust networks, ensure member access to coordinated care via managed care networks, and facilitate meaningful partnerships between plans and providers to move from volume to value in the Oklahoma Medicaid program.

Our experience has shown that the development of a new program often creates a unique opportunity for providers to leverage the fact that MCOs must build networks with sufficient access to services as an opportunity to attempt to negotiate rates in excess of the FFS published rate. This results in unintended increase in costs to the program and creates an unlevel negotiating position for MCOs. To minimize this risk, we recommend establishing a maximum provider payment ceiling of 100% of the FFS published rates. The exception to this ceiling would be if the MCO and provider negotiate a mutually beneficial relationship where payments above 100% of the FFS published rates are tied to an APM or in circumstances where, given specialist shortages, negotiating above the FFS published rates are in the best interest of members' ability to access targeted specialty care.

3) What is appropriate for timely payment of claims?

We recognize how important timely claims payment is to providers to support their ability to provide care and to OHCA. We recommend that OHCA set goals for clean claims based on 30 days and then based on 90 days to ensure that MCOs focus on payments in a timely manner. Several states require that MCOs must pay or deny 90% of all submitted clean provider claims, including those from Indian Health Service (I/T/Us), within 30 days of receipt, and 99% of all submitted claims within 90 days of receipt.

4) What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

The transition to managed care can be one that is challenging for providers, and for it to be successful, a high level of coordination and communication needs to happen on both the state level and with MCOs. Standardizing some processes or functions can be helpful in this transition, however, standardizing too much can jeopardize the benefits of moving to managed care. We recommend that OHCA weigh the value of standardization with the value that innovation can bring from the MCOs. There are opportunities for OHCA, MCOs, and providers to find common solutions in areas that affect member experience, quality, program integrity, and administrative simplification such as:

- ***Align quality and performance measures:*** OHCA can ensure that MCOs and providers are aligned with shared priorities by identifying the most critical quality and performance metrics - including member experience measures. We recommend that OHCA engage providers, MCOs, CBOs, and members to identify aligned measures to support system change. While OHCA will hold the MCOs accountable for the same measurers, there are variations in which

measures providers can or are willing to focus on. In addition, this is an opportunity to incorporate aligned measurers on activities that address social determinants of health (SDOH) such as housing and nutrition

- ***Improve data sharing:*** With appropriate privacy and security safeguards, increased bidirectional data access between MCOs and providers to reduces time consuming and error prone manual work such as in the collection of quality data for HEDIS. This could be accomplished through collaborative workgroups
- ***Reduce prior authorization discrepancies:*** We acknowledges that variances may exist between MCOs as part of their operating strategies related to the determination of services requiring prior authorization. MCOs should collaborate on establishing standardized authorization requirements, forms, process and requirements, including minimally necessary information to be submitted by providers. Providers benefit from reduced variations, lower administrative challenges and could result in fewer claim denials and/or rework of authorizations and claims
- ***Clarify claim denial reasons:*** We have long supported the use of nationally recognized standards and recommends all MCOs use reason codes approved by the American National Standards Institute (ANSI) Insurance Subcommittee to communicate consistent explanations on denials of service. This will clarify claim denials, allowing providers to avoid administrative effort in understanding a denial and determining what steps are necessary for resubmission
- ***Establish centralized credentialing:*** Based on our experience with other states that have used a similar approach, we recommend OHCA consider implementing a successful centralized credentialing structure that includes:
  - Using a nationally recognized credentialing entity for gathering centralized credentialing data (e.g., Council for Affordable Quality Healthcare (CAQH)
  - Contracting with an NCQA certified credentials verification organization (CVO) to perform the primary source verification function
  - Requiring the contracted CVO to work collaboratively and establish workgroups with all MCOs (and encouraging provider organizations to partner as well) on building a successful centralized credentialing process
  - Ensuring the credentialing and recredentialing process meets NCQA guidelines standards, applies standards consistently across MCOs, and captures information on a provider's hospital admitting privileges
  - Working with the MCOs to define parameters on the history of malpractice settlements
  - Allowing MCOs to have delegation of credentialing arrangements in place with entities performing credentialing activities
  - Taking into consideration that MCOs credential providers simultaneously for multiple lines of business (i.e., Commercial, Medicare, and Medicaid) when defining the scope of the centralized CVO process
  - Encouraging the inclusion of behavioral health providers by incorporating an ASAM-based credentialing process
- ***Promote transportation access:*** To reduce the no-show rates, we recommend encouraging the use of app based and ridesharing options so that transportation is more accessible to SoonerCare members

5) How can MCOs best communicate to providers about updates and changes to plan policies?

We recommend using a variety of approaches for provider communication, since all providers have different preferences. Regardless of communication medium, what is communicated must remain consistent. A readily accessible statewide portal is key for providers to quickly access information on individual members, submit claims and see changes, however, it is important that is not the only place where changes are posted. Regular written communication and updates from provider advocates, are important to reinforce what is shared on the provider portal.

6) How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

There is no one approach that will work the best, especially in the transition from an FFS program to managed care. Prospective MCOs should be ready to do what it necessary to ensure that providers are prepared when the program starts. This includes education, training, and communicating in many forums to ensure readiness and promote understanding, minimize complaints and continually evaluate areas of the processes and so they are ready. For example, in other startups we use internal and external resources to minimize provider burden with the application process, source verification and contract completion activities. We use the tools that are available to providers at no charge and streamline the provider data collection administrative process for credentialing. During the readiness phase of the implementation it is vital for MCOs and the State to establish a process to listen to providers to ensure their understanding and test their knowledge of important processes. We recommend that OHCA have regular listening sessions with providers during the readiness phase to ensure that they understand the change, and check-in regularly with the successful bidders to ensure they are doing the same.

7) What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

OHCA should allow MCOs to design unique value-based models that ensure that members' needs are addressed and providers are appropriately supported and incentivized. MCOs should tailor agreements and related supports to fit mutual needs. We have learned that our provider partners are in very different places in their journeys towards accountability for outcomes. The flexibility to meet providers wherever they are and invest in their capacities to become even more effective partners in managing care to deliver better outcomes is essential for delivery system transformation.

We recommend the State consider where thoughtful standards and common frameworks offer the best potential for reducing provider abrasion, do not meaningfully differentiate payers, and do not add value when conducted multiple times (e.g., quality measurement definitions). Areas ripe for "utility" approaches, where the State brokers alignment between MCOs, include provider primary source verification for credentialing, quality measurement frameworks and definitions, risk adjustment, trend adjustment, etc. In exchange, we recommend the State allow MCOs flexibility in structuring contracts that incentivize the behavior changes needed to improve population health outcomes.

8) How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

UnitedHealthcare encourages OHCA to work in tandem with MCOs to optimally support providers in increasing their capacity to focus on care delivery and supporting their transformation toward community-integrated population health management. This includes, but is not limited to, well-

informed whole person integration of care, favorably affecting SDOH and measurably improving health outcomes and disparities. MCOs can ease the administrative burden of network providers, reward high performing providers for their commitment to achieving clinical integration and comprehensive population health management and identify opportunities to collaborate more closely in achieving aligned objectives.

We value the important role of federally qualified health centers (FQHCs) in promoting targeted population health goals and caring for traditionally underserved populations. Our national experience has demonstrated that MCO-operated walk-in clinics are ineffective at driving meaningful results and could divert resources away from existing local PCPs. This knowledge reinforces the importance need of OHCA to ensure MCO partners demonstrate a commitment to supporting providers' ability to effectively meet the needs of members and their communities. We encourage OHCA to work with MCOs to test innovative payment and delivery system reform initiatives that can further promote patient-centered medical care with a focus on care coordination and management for members. For instance, MCOs can use CHWs to connect members to PCPs and avoid unnecessary ED utilization. MCOs can use clinical practice consultants and deploy alternative delivery models such as paramedicine and telehealth to further enhance provider capacity and increase access to care. OHCA can also incent MCOs to encourage provider-led clinical-community integration through advanced payment models and data sharing.

PCPs could benefit from:

- Online functionality for authorization requests and claims submissions/lookups
- Provider scorecards to inform and educate for practice enhancements
- Remote training opportunities
- Provider relations managers assigned to each practice to serve as a primary point of contact on all questions and issues

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

Examples of industry standards include:

- Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
- Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
- Require all Primary Care Providers have at least some same-day acute care appointments
- Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)
- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

1) How should MCOs work with providers to ensure timely access to care standards are met?

MCOs should educate providers on timely access requirements through provider orientation and have accessible through the provider manual for reference. Ensuring that appointment availability standards are met will help members obtain necessary care more efficiently and we encourage additional coordination between OHCA and MCOs occur to standardize tools and methodologies. This should focus on outreach frequency reduction to providers to monitor these activities. Without increased levels of coordination, this measure could unintentionally increase provider burden.

The best practice for monitoring appointment availability standards is through secret shopper surveys, where researchers or a staff member call provider office to determine true wait times for accepting new Medicaid patients.

Provider field staff should be trained to have conversations with providers who are not able to meet standards, or the MCO must be able to find additional capacity when there are confirmed gaps. Providers challenged with meeting access standards should be advised on operational enhancements such as telehealth and variable appointment scheduling options to reduce lost time for no-shows. MCOs should also demonstrate commitment to working with providers to eliminate barriers to timely access to care, including appropriate and targeted investments with providers to assist them in expanding capacity – particularly in underserved areas of the state.

2) What are reasonable time and distance standards in Oklahoma by provider type?

Urbanicity should not be used in isolation to determine time and distance requirements. Rather, states should determine ideal driving times and distances based on existing standards and literature and adjust as needed to accommodate insufficient supply and/or provider capacity. County designations can serve as a strong foundation for time and distance standards, but in some counties and/or regions, provider supply and capacity will not be sufficient to meet standards for that designation. While states can use an exceptions process in these instances, building this consideration into the criteria will reduce administrative burdens on the state by reducing the need for exceptions.

Given the geography of Oklahoma, we encourage OHCA to consider provider supply when implementing network standards rather than requiring exception requests in these instances.

Provider supply should inform both the minimum number requirement and time and distance standards to minimize exception requests in instances where OHCA's preferred standards are unattainable and more realistically reflect actual accessibility to providers and local patterns of care. OHCA should focus on provider types with high utilization among the Medicaid population when determining the types for which time and distance standards will exist.

3) How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

The transition to managed care can be challenging and it will be vital to ensure that there are enough providers in each MCOs network to meet the needs of the state. To resolve this issue, we recommend the following:

- Value based contracts that begin to pay out in a short period of time
- Dedicated resources to ensure that providers can understand and resolve issues
- Collaboration between providers and community organizations to establish new ways to work together incorporating social, behavioral and physical needs
- Provider advisory groups to listen to the reason's providers are apprehensive to join a MCOs network
- Investment in local infrastructure to encourage participation in the network, including the use of Community Extenders to connect members to PCPs
- Eliminate any regulatory and/or programmatic restrictions regarding providers' ability to practice at the top of their license

4) How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

The challenges of sourcing and retaining direct support workers is the responsibility of all the partners in the system, including MCOs, state entities (local community governments to become engaged in solving for the issues), and providers. OHCA could convene a workforce development committee with intentions to understand the workforce that provides services to Medicaid members. The goals and objectives set forth for workforce development in managed care programs cannot be accomplished without a collaborative effort to achieving these goals. Recommendations to address workforce challenges include:

- Investment in providers to assist with staff development programs and additional ongoing training, which includes some MCO-sponsored training, such as the Skills System
- Partnering with education and community organizations to promote and advance training opportunities within the institute
- Portability training for workers (option to take trainings from one provider to another)
- Increased pay and/or incentives for workers
- Campaigns and marketing to provide education to varying specialties (e.g., nurses, behavioral health clinicians, therapists) around the opportunities of this workforce
- Collaborative internship program to have successful providers partner with MCOs to focus on high schools and offering school credit opportunities for students to promote and educate on what a Direct Support Worker DSP does (e.g., all roles – direct care, employment)
- Combining resources, such as the possibility of using a staffing agency, for providers to obtain employees

- Centralized portal to connect providers with qualified candidates
- Improvements to Reportable Events and system responses to reduce punitive processes in response to the investigation results. Implementing portability of the training for workers will increase provider's ability to put already trained and competent workers in the field sooner

Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

1) How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

MCOs should have a set of well-described, detailed processes, and procedures for receiving, tracking, responding to, reviewing, reporting and resolving complaints and appeals. Member complaints and internal appeals policies and procedures should be based on OHCA guidelines and requirements. Upon enrollment, members should receive oral and written information regarding the complaint and appeal system, including pertinent policies and procedures and specific details on filing complaints, appeals and state fair hearings. Members and their representatives should be treated with respect and provide access to all necessary information.

From our experience, mandated turnaround times for responding to grievances and appeals protect members and provides them with clear expectations for the appeals and grievance process. The ability for members to file an expedited appeal or file an extension to provide additional information to support their grievance or appeal also protects members. It provides them with ample opportunity to voice their concerns or complaints regarding their care.

Members should submit grievances to their health plan via the call center or through written correspondence as health plans are in the best position to address the issue. Grievances submitted to other areas of the organization or to parties outside of the organization may result in untimely resolutions which would not efficiently address our members' concerns.

2) How can the state and MCOs use appeals data to improve utilization management and access?

The complaints and appeals should be logged into a tracking system to log, track and report all complaints and appeals activity to make sure requests are processed timely using appropriate procedures. Data should be monitored, including appeals overturn rate, compliance rate and acknowledgement letter rate, to allow MCOs to maintain high standards, reduce rework of appeals and improve customer service.

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- Gain accreditation by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- Maintain an Oklahoma presence, including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- Participate in the state Health Information Exchange to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

1) How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data do require?

The Centers for Medicare and Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) seeks to shift the health care system to greater interoperability, while allowing patients enhanced access to their health records. The final rule goes into effect for MCOs at the end of 2020 and CMS intends to begin enforcement in 2021. The rule defines requirements and standards for data interfaces for health care data over secured public Application Programming Interfaces (API). Electronic health record (HER) and other patient management systems will likely be required to adopt similar standards.

The CMS final rule will highlight the importance of security, as it allows entities not traditionally part of the health care landscape to access health information. For example, the use of wearable technology and mobile devices are not subject to HIPAA rules, as the vendors are not 'covered entities" and members are explicitly choosing to share their data to the apps, and therefore the app vendors. App vendors can use and resell member data in any way they choose, if acceptable under the 'terms of service' the member agreed to. A national regulatory framework is needed to control this issue and individual states should not try to fill that void as it results in a regulatory patchwork and greatly increases costs of compliance.

Traditional data exchanges should use the CMS adopted standard of HIPAA compliant X12 Version 5010. Any portals or public APIs should include encryption, 2-factor authentication, and security controls. For overall security standards, processes, and procedures, we recommend using the common commercial framework called HITRUST. Most of the commercial health insurance industry is using or moving to this framework. CMS requirements for Medicaid MMIS platforms point to using a framework based around NIST 800-53, which in an established, large-scale IT ecosystem is prohibitively expensive to implement and operate. The HITRUST framework is aligned to the NIST framework but provides key flexibility in mitigations.

We recommend OHCA use a member opt-out approach instead of requiring members to opt-in, as we have found that opt-in approaches have made HIE adoption difficult in several states.

2) What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

We encourage OHCA to leverage its existing infrastructure to develop data sharing pathways at the Medicaid agency level and passing along the detail at the individual level through mechanisms such as the 834-file transmission to facilitate systematic sharing of information to Medicaid contractors.

3) How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

The ability to be flexible in the application of prepay edits is an important consideration in fraud, waste and abuse management. The goal for every Medicaid program is to make sure that the right people get the care they need and providers are paid promptly and accurately for their services. However, fraud, waste and abuse persist in the billing and payment systems. Post-payment efforts are commonly used to detect and recover overpayments; however, this is a time- and resource-consuming process. To operate a cost-effective system, MCOs should focus their work on the strategies that will deliver the best return. Prepay edits allow for risks to be determined earlier in the process. Automated prepay edits allow more claims to be processed and allow for prioritization of claim reviews. Prepay edits reduce provider abrasion by allowing adjustments before a claim is paid, thus reducing the burden of pay-and-chase methodologies.

Various types of prepay edits exist, including the following: unit, duration, or frequency limitations; conflicts between 2 or more codes; proper use of modifiers; provider-specific concerns; and others. The variety of prepay edits underscores the need for flexibility among the MCOs and flexibility over time so that prepay edits can be adjusted to situations and can be adjusted as claims patterns change. Prepay edits produce various outcomes including the following: automated claims denial; auto-adjustment of the claim; flagging the claim for further review; and mandating submission of medical records for clinical review. It is important to maintain a variety of potential outcomes of prepay edits to account for the variety of fraud, waste and abuse concerns that exist.

It should be noted that prepay edits will not eliminate the need for post-payment interventions. Prepay edits will detect errors not found in post-payment processes and post-payment insight can further improve the accuracy of prepay edits. By incorporating the valuable insight between prepay edits and post-payment processes, MCOs can improve the accuracy of identification, acquire additional audit case support, identify system vulnerabilities, pinpoint inaccurate front-end system edits and identify ineffective policy rules. When pre- and post-payment intelligence are shared, agencies create a continuous cycle of improvement that can transform overall operations for increased return.

While we support the concept of requiring prepay edits and would be open to the idea of some baseline areas (common across MCOs) where prepay edits would be required, we believe that there will always be the need to adjust prepay edits. We suggest that routine and ongoing collaboration meetings between OHCA and MCOs would allow for continuous evaluation of the effectiveness and efficiency of required baseline prepayment edits and allow for MCO-specific exemptions.

We also suggest that it is better for MCOs to develop specific analytics independently to allow for greater innovation by MCOs and prevents providers from finding a single gap that allows problematic billing across MCOs. It would also be helpful for MCOs to discuss schemes and areas for intervention, without disclosing proprietary methodologies.

Prepay edits present opportunities beyond intentional provider behavior. There are also opportunities to apply prepay edits on a member-specific basis to find where member behavior is problematic, such as receiving the same services or equipment from multiple providers. There are also opportunities to analyze historical error patterns and use those patterns to inform new prepay edits that seek to identify erroneous billing for education of providers for more appropriate billing and policy edits that seek to clarify expectations and acceptable practices.

In summary, UnitedHealthcare supports the concept that MCOs should use prepay edits to combat fraud, waste and abuse. Experience tells us that prepay edits need to be flexible over the course of time because provider behavior changes and the landscape of health care services continues to change. When MCOs can be innovative in the application of prepay edits, we are better able to capture and correct problematic billing behavior.

4) Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

If OHCA intends to mandate Marketplace participation, we recommend the mandate allow regional participation and not require MCOs to offer plans statewide. Regional participation allows MCOs to develop competitively priced networks and better meet network adequacy standards in specific regions. A statewide participation mandate could result in increasing instability in the market and reducing choice, if insurers decide that complying with the participation mandate is too onerous and withdraw from a market.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Oklahoma City Area IHS
701 Market Drive
Oklahoma City, OK 73114

AUG 2 1 2020

Mr. Kevin Corbett, CEO
Oklahoma Health Care Authority
4545 N. Lincoln Boulevard
Oklahoma City, OK

Dear Mr. Corbett:

I am responding to the comment period on the announcement of the Oklahoma Health Care Authority's intent to seek proposals from qualified managed care organizations (MCOs) for the Medicaid Program (SoonerCare).

Along with our tribal and urban partners, we appreciate the OHCA developing the OHCA/Tribal MCO workgroup. We have attended two meetings to date and look forward to future meetings to continue these important discussions. While we have touched on many of the concerns that have been presented in the meetings, we want to reiterate that it has been our experience that the IHS does not fit well within a managed care system, as the Indian health system already performs similar to a managed care organization. We offer the following specific comments to the proposal:

- Duplication. As noted, the IHS system already comprises an integrated and coordinated health care system that requires specific authorizations for referred care. Adding another layer to these requirements would create confusion for our patients and administrative challenges for our staff, the OHCA and the managed care plans.
- Lack of familiarity with IHS. As a federal health system, IHS' authorities that supercede State law are often overlooked by managed care organizations who have expertise in State law. For example, in Kansas, we have experienced numerous issues with the managed care programs not processing our claims at the correct rates, denying claims for being out of network, as well as denying covered services such as dental and specialty services that are indeed covered under our current agreements. All of these are issues because of the special authorities and protections for Indian patients administered by CMS, which the managed care organizations are not knowledgeable about and which they usually are not set up to address.
- Auto-enrollment. We request that American Indian and Alaska Native patients not be auto-enrolled. Choice in health care is foundational to the many statutory protections for American Indian and Alaska Native patients in the health care reform efforts. We would like to note as well that auto-enrollment may have the result of reducing amounts recovered through the FMAP.
- The United States recognizes Indian Tribes as sovereign nations. This unique government-to-government relationship between tribes and the federal government requires federal and state agencies to engage in meaningful consultation with tribes. This type of communication may be damaged when an MCO is used as an

intermediary to carry out the State's unique government-to-government responsibilities. Many times the MCO acts as a representative of the government in these communication processes, which may not meet the intent of the executive order or state policies on tribal consultation.

Our recommendation is that the existing integrated and coordinated care established for the Indian health care system be leveraged as a distinct managed care organization within the proposed managed care model for SoonerCare. If the decision is made to pursue managed care as proposed, we would respectfully request that a point of contact at the OHCA be assigned to represent the I/T/Us and work with the managed care plans to resolve any claims issues. It would present a significant challenge for I/T/U sites to work with three or more managed care plans and try to educate their staff on how claims are to be processed and paid according to our rights that have been established by law.

Thank you for the opportunity to comment and we look forward to further discussion.

Sincerely,

for RADM Watts

RADM Travis Watts, PharmD, BCPS
Area Director

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BILL ANOATUBBY
GOVERNOR

August 12, 2020

Mr. Kevin Corbett, CEO
Oklahoma Health Care Authority
Federal Authorities Unit
4345 North Lincoln Boulevard
Oklahoma City, OK 73105

Dear Mr. Corbett:

On behalf of the Chickasaw Nation, we are pleased to offer comments in response to the Oklahoma Health Care Authority Planned Comprehensive Medicaid Managed Care Implementation.

The Chickasaw Nation has a great working relationship with the Oklahoma Health Care Authority in supporting our tribal health care system. We appreciate your willingness to develop a state/tribal workgroup to address the third party managed care organization issues related to the American Indian/Alaska Native population within our state. The workgroup has held two meetings and has discussed many topics of concern related to the American Indian/Alaska Native population.

In the absence of having the ability to review either the Request for Proposal or the Waiver Amendment submission to the Centers for Medicare and Medicaid Services, we are submitting the attached comments and recommendations for the record.

If you have any questions, please contact Dr. Charles Grim, secretary, Chickasaw Nation Department of Health, at charles.grim@chickasaw.net or at (580) 421-6247.

Sincerely,

Bill Anoatubby

Bill Anoatubby, Governor
The Chickasaw Nation

BJA:mag

Enclosure

CHICKASAW NATION COMMENTS TO THE OKLAHOMA HEALTH CARE AUTHORITY PLANNED COMPREHENSIVE MEDICIAD MANAGED CARE IMPLEMENTATION

On June 18, 2020, Governor Kevin Stitt and Oklahoma Health Care Authority (OHCA) CEO Kevin Corbett announced that the state would seek proposals from qualified managed care organizations (MCOs) to improve health outcomes, increase access to care and increase system accountability in the Medicaid program (SoonerCare). The Request for Proposals (RFP) is currently in development, with a planned release this fall and an anticipated implementation date of October 1, 2021.

During the July 7, 2020 tribal consultation meeting, the following was an agenda item:

Third Party Managed Care Organization - To improve Oklahoma's health outcomes, increase access to health care and foster a more accountable system, the OHCA will seek proposals from qualified managed care organizations to facilitate health care services to eligible and enrolled members of Oklahoma's Medicaid program, commonly known as SoonerCare. Following the request for proposals and to obtain authority to establish the managed care organization, the agency will seek to revise/add federal and state policy including: 1115 and 1915 waiver requests, Title XIX and XXI state plan amendments and state rules.

A state/tribal workgroup was developed to have further discussion and develop recommendations for the MCO RFP. The first workgroup meeting was held virtually on July 21, 2020. The following is a recap and recommendations:

The workgroup consisted of representatives from the Chickasaw Nation, Choctaw Nation, Cherokee Nation, Citizen Potawatomi Nation, Iowa Tribe, Oklahoma City Indian Clinic, Indian Health Service, and Wichita and Affiliated Tribes. While the open discussion focused on several areas of concern, the top recommendation was for OHCA to create and administer a care coordination model specific to American Indian/Alaska Native (AI/AN) population in lieu of contracting directly with MCOs. This model would be similar to the AI/AN Patient Centered Medical Home proposal that was designed from Arizona's plan. If OHCA did not choose to allow the AI/AN PCMH model, then the following recommendations would apply:

- Opt-In: Auto enrollment of AI/ANs into an MCO would decrease the member's opportunity for choice. Members will be driven away from care at Indian health care facilities, as they would follow the MCO guidance on alignment within their provider network.
- Provider Network: Through their current referral system, the Indian health care system has an established provider network. There is a concern that a MCOs network will not coordinate with the Indian health care system networks, thus creating a problem with securing referrals for their patients.
- Care Coordination: The Indian healthcare system already reports measures to HHS through the GPRA (Government Performance and Results Act) system. Several tribes, including Chickasaw Nation, use the Resource Patient Management System platform for health information. MCOs requiring additional reporting and interoperability would create an additional administrative burden to the Indian health care system.

- Sovereignty: Tribes seek contract language with MCOs that is similar to their current OHCA agreements that recognize tribal sovereignty. Tribes do not want to waive sovereign immunity.
- OMB Encounter Rate: CMS requires MCOs to pay the OMB encounter rate. However, the OMB encounter rate full payment is available through a 'settle-up' agreement or 'wrap around payment' with the state Medicaid agency thus creating an administrative burden on the ITU.
- Benefit of MCO: A tribe that operates smaller health care facilities noted that it wouldn't be able to meet all the criteria of an Indian PCMH model; and that moving to an MCO would alleviate some of their administrative burden to carry out optimal care coordination.

The second workgroup was held virtually on July 30, 2020. OHCA reported that the recommendations from the first meeting were submitted to leadership. OHCA reported it is not planning on implementing a specific Indian managed care model and moving to an opt-out model, rather than an opt-in model. They also reported they want to work with the workgroup to develop a process that will be efficient, stream-lined and electronic. Significant concerns about transitioning SoonerCare to an outside managed care model were discussed, as such models present unique administrative and care coordination challenges for the patients we serve. Brainstorming brought about a few new ideas, such as:

- Grandfathering of the current AI/AN patients as an automatic opt-out group, which would ensure our patients the continuing of remaining with their current primary care provider. An online option for AI/AN patients to indicate they are a current patient at an Indian health care facility which would trigger an opt-out of managed care. OHCA reported there are 90,520 verified AI/AN patients currently and this population would remain with the Indian health care facility as their primary care provider.
- Ensure each of the MCOs has a designated tribal liaison on their staff as a contact for Indian health care providers.
- An established reason for making plan changes should be to change their primary care provider to an Indian health care provider.
- OHCA should ensure the PCMH payment continues to be remitted to the Indian health care facility.
- Tribal Medicaid Administrative Match and Agency View should remain operational at its current status.
- Tribes requested to begin discussion with OHCA on creation of an Indian Managed Care Entity and to ensure that the RFP includes language that would allow an IMCE to capture their full patient population.

Concerns and Recommendations:

AI/AN should not be auto-enrolled in managed care, which will ultimately cost the state more. While it may seem reasonable to assume that including all AI/AN in managed care would

increase the managed care pool, and therefore allow the OHCA to negotiate a lower per-person rate with the MCOs, we question whether that will bear out in the case of AI/ANs. Having an opt-out provision could result in a larger pool which may lead to lower initial per capita costs for purposes of negotiating an amount with the MCOs; however, it will not translate to lower overall costs for the state. This is because the state will have to pay the MCO based on the assumption that all AI/ANs stay in, and if many opt-out, then the state may be paying for them. Unless the state gets the anticipated opt-out percentages calculated correctly, the state could be on the hook for significant additional costs that could dwarf any savings it might get by having a larger actuarial pool by implementing it as opt-out. As a result, an opt-out policy for AI/AN puts the risk of making a mistake in opt-out rate on the state. An opt-in policy for AI/AN, on the other hand, puts the risk on the MCOs. If more AI/ANs opt-in than expected, the additional costs will be borne by the MCOs, not the state. As a result, opt-out creates significant financial risk for the state, while opt-in does not.

- **Medicaid Managed Care has been very difficult to implement in Indian country.** MCOs often have little to no familiarity with the Indian health system and routinely disregard the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal laws. Indian Health Care Providers (IHCPs), which include the Indian Health Service, tribal and urban health systems, cannot sign most MCO provider agreements because they contain provisions that are not designed for tribal governments or federal Indian health care providers, and MCOs routinely use a one-size-fits-all approach to contracting, often refusing to negotiate the terms of those agreements with IHCPs. For example, MCO contracts impose state licensing and credentialing requirements on IHCP providers they are not required to meet, or are inconsistent with federal law. MCO contracts contain payment mechanisms inconsistent with IHCP reimbursement rights under the Medicaid statute. MCO contracts contain prior authorization requirements that are inconsistent with IHCP rights under the Medicaid statute and Managed Care Rule, and MCO contracts require insurance coverage requirements inconsistent with IHCP coverage under the Federal Tort Claims Act.

  MCOs then routinely refuse to pay IHCPs even though they are required to by federal law when IHCPs are out of network, requiring significant additional work on the part of the state, CMS and the tribes to work out reimbursement mechanisms and compliance. Even after education on the IHCP protections, MCOs must make system changes to ensure that claims from IHCPs are not routinely rejected. MCOs in many states have never been able (or willing) to accomplish this. MCOs impose care coordination and prior authorization requirements that may improve patient care for non-Indian Medicaid enrollees, but which are fundamentally inconsistent with how IHCPs already manage their patients' care.

IHCPs already provide care coordination. Unlike the non-Indian provider system, the Indian health care system in Oklahoma is already an integrated care delivery system. Its clinics and

hospitals have developed sophisticated patient engagement, care integration and referral and outreach delivery systems. Examples include chronic disease management; population health; integrated behavioral health; integrated pharmacy; ancillary services such as lab and radiology; specialty care; optometry and dental; and environmental facilities services such as safe water and sanitation, and injury prevention. In addition to health services, most tribes have other governmental services such as housing, family services, transportation, nutrition, higher education and training. IHCPs (no matter their size) already coordinate care between our direct system, purchased and referred care provider network, between other IHS/tribal systems, Veterans Health Administration and others. Layering an MCO's different coordination system on top of the IHCP system is wasteful, confusing for patients and will be fraught with administrative complexity.

- **Congress enacted special Indian Medicaid managed care protections to help address these issues.**
  - SSA 1932(a)(2)(C) provides that no Indians may be mandatorily enrolled in managed care through a State Plan Amendment
  - American Recovery and Reinvestment Act of 2009, P.L. 111-5 (Feb. 17, 2009), provides Managed Care protections in Section 5006 – a summary:
    - 5006(a), Exemption from Medicaid cost sharing (including co-pays) for Indian patients served by IHS, tribal and urban Indian organization (I/T/U) providers, including referrals under Contract Health Services (CHS) program
    - 5006(b), Exemption of certain Indian-owned property from being considered as "resources" for purposes of eligibility of individual Indian for Medicaid and CHIP
    - 5006(c), Codification in law of current policy which protects certain Indian property from Medicaid estate recovery
    - 5006(d), Protections for individual Indians and Indian health care providers in states which operate Medicaid through managed care organizations
    - 5006(e)(1), Continuation and expansion of TTAG chartered by CMS
    - 5006(e)(2), Requires States to consult with I/T/Us within the State on proposed changes to Medicaid and CHIP programs
  - The Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3 (Feb. 4, 2009)
    - Section 211 makes tribal enrollment document the equivalent of a U.S. passport for the purpose of proving U.S. citizenship for Medicaid eligibility.
    - Section 202(a), to improve access of Indians to Medicaid and CHIP, requires CMS to encourage States to provide for enrollment services on and near Indian reservations.
    - Section 202(b) makes the 10% cap on State CHIP outreach expenses inapplicable to expenditures for outreach to Indian children.

CHICKASAW NATION COMMENTS TO THE OKLAHOMA HEALTH CARE AUTHORITY PLANNED COMPREHENSIVE MEDICIAD MANAGED CARE IMPLEMENTATION

- **The Centers for Medicare and Medicaid Services (CMS) implements the Indian managed care protections.** CMS requires freedom of choice and for AI/ANs who wish to enroll in an MCO to be allowed to do so. CMS' managed care rule at 25 C.F.R. 438.14 codifies the ARRA Indian managed care protections. CMS further does not permit states to require mandatory enrollment of AI/ANs through a SPA due to SSA 1932(a)(2)(C), and CMS has never permitted a state to require mandatory enrollment of AI/ANs through a Section 1115 waiver. CMS requires states to ensure their managed care plan agreements require the MCOs to follow the Indian managed care protections. When a state does not require the MCOs to pay Indian health care providers at the OMB encounter rates, CMS requires the states to make a wrap payment to IHCPs to make them whole. CMS has required states to require that MCOs offer to contract with IHCPs in their area, and has developed an Indian managed care addendum for MCO contracts with IHCPs that CMS encourages states to require for contract execution.

  Although both Congress and CMS have recognized that Indian managed care protections are important, they do not solve all of the issues with managed care in Indian country.

- **Oklahoma has an opportunity to design a system that complements the Indian health system, rather than one that creates barriers for AI/AN patients.** The Indian managed care protections are important for AI/ANs who elect to enroll in managed care, but they are not the best solution for state or the Indian health system in Oklahoma. The Indian managed care protections take specialized knowledge and the administrative complexity to implement on the part of the State in its oversight of MCOs and on the part of the Tribes in working with the MCOs, the State and CMS.

  A better solution is to enhance the care coordination models that have already been developed in the Indian health system that address the uniqueness of our people in Oklahoma and that would result in improved outcomes, engagement and tracking for our high-risk population. Tribes would like to work with the state to create a patient-centered care coordination model specific to the Indian health system that would work for IHS, urban Indian programs and tribes, regardless of their size. This would provide incentives to enhance care coordination between IHS, tribal, urban and outside providers for AI/AN Medicaid participants, and are most familiar with local resources, services available and tribal culture. CMS has approved similar waivers like the Arizona Indian Medical Home model, and others – examples that have been provided during workgroup meetings. The state could also build the model to allow IHCPs to provide any enhanced services that the new managed care program might include.

  Once in place, the state would not be required to spend resources routinely brokering disputes between MCOs, the Indian health system and CMS – something we have witnessed happen in other states, even states that have had managed care for decades. It is a cyclical set of problems that never really go away. Such a model should increase patient care and

health outcomes at no additional cost to the state. It would also allow the state to streamline the identification of services reimbursed at 100% FMAP and more accurately claim the full match. If claims are paid or partially paid by a MCO to IHCPs, there is much more administrative burden in identifying and claiming the full FMAP, likely resulting in lost revenue back to the state. Such a model would eliminate duplication for the patient in coordination of care, and for seeking referrals and approvals for higher levels of care. The patient having to navigate the first level of referral/approval at the IHCP, and then forced to wait for duplicative approvals by a MCO.

- **Conclusion.** Given the uniqueness of the Indian health system, as well as significant complexities in administering the Indian managed care protections, we strongly urge the OHCA to consider: (1) not auto-enrolling AI/AN into managed care; and, (2) creating an Indian patient-centered care coordination model as described above. We further request follow up meetings through the OHCA/Tribal Workgroup and tribal consultation on the issues presented herein.

Thank you for the opportunity to provide comments and recommendations We look forward to further collaborating on a productive and effective model for the SoonerCare program.

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SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

Oklahoma Primary Care Association (OKPCA) has reviewed the questions posed in Oklahoma Health Care Authority's Request for Information (RFI) related to the SoonerCare Comprehensive Managed Care Program (80720200002). OKPCA's submission includes a letter to OHCA as well as responses to specific questions posed in the RFI, bolded below.

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?
    - **OKPCA: OHCA should reinstitute their annual strategic planning retreats to include stakeholder involvement. This topic should be discussed and evaluated annually with stakeholder input. Alternatively, this should be discussed annually through the BHAC, the MAC and the DUR Committee to determine provider and MCO/ACO readiness and reported up to the OHCA Board. It will be important to have general consensus that the program is running smoothly and that system issues have been worked out and resolved as well as to ensure adequate integration and coordination between the primary care provider networks and the behavioral health and long term care provider networks prior to enrollment of these vulnerable populations.**
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
    - **OKPCA: With proper planning, certain populations could be "carved out" of participation in an MCO both through having mechanisms to prevent them from being enrolled as well as by having mechanisms in place to disenroll them from the MCO upon identification of them meeting the eligibility criteria (for example, the SBHN – Special Behavioral Health Needs – disenrollment process that was developed through the SoonerCare Plus program). Ideally, all participating MCOs should eventually have the willingness and capacity to serve all populations to**

minimize system fragmentation and increased administrative costs and burdens to providers.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?
    - **OKPCA: Require plans to reimburse for care coordination and community health and wellness workers. Provide plans with incentives for tracking these health outcomes and encourage them to implement population health initiatives and outcome tracking. Encourage them to offer providers an enhanced rate or incentive for meeting their target goals (i.e. 75% of patients seen for annual wellness visit, 75% of patients screened for tobacco use annually and subsequently referred to Quitline, behavioral health provider or provided tobacco cessation intervention). Provide incentives to plans and providers who utilize technology to improve clinical and health outcomes. Additionally, OHCA could contract directly with ACOs and other clinically integrated networks that have demonstrated success in the utilization of population health and care coordination services to encourage healthy behaviors of members.**

Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure appropriate and sufficient behavioral health care, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services –

    - **OKPCA: This should be changed from "allow" to "require."**
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
    - **OKPCA: Changing to "operate or contract for" would allow plans to contract with Heartline, for example, or they could collaborate to have one line for all to call so that it isn't a different line and system for each plan**
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in Social Determinants of Health strategies, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers
- Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
    - **OKPCA: Allowing for continued use of telehealth would better enable recipients access care. OKPCA recommends requiring MCOs to allow the FQHC to serve as the PCP or to allow for other FQHC providers to provide PCP care in addition to the identified PCP without penalty to the FQHC, the provider or the patient. And, develop a process to auto-assign existing FQHC patients to an MCO that is contracted with the FQHC and for auto-assigning the FQHC as the PCP (for example, FQHCs could provide OHCA with a report of current Medicaid patients for auto-assignment at the start of program implementation). Also, program design should include a process for providers to assist members/patients with switching MCOs, outside of open enrollment, if the patient mistakenly enrolls in an MCO that the PCP is not contracted with. Additionally, the RFP should require all participating MCOs to offer contracts to all safety-net providers such as FQHCs.**

- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?
    - **OKPCA: Offering incentives to ACOs and other clinically integrated networks that include CCMHCs, CMHCs and CCARCs as part of their network and by requiring MCOs to do the same, and by offering incentives to providers who have staff trained in trauma-informed care.**
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?
    - **OKPCA: By offering incentives to providers who utilize SBIRT, have mechanisms in place to assess and address SDOH and who staff that are trained in trauma-informed care.**
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
    - **OKPCA: By requiring MCOs to reimburse for these services and by not allowing them to require prior authorization for screenings such as SBIRT and by encouraging them to offer provider incentives based upon successful tracking of these outcomes (i.e. provider bonus for reaching target goal of completing annual SBIRT screen on 80% of patients). By requiring MCOs to reimburse for MAT medications and provider services without prior authorization requirements and by requiring them to work with the OSU TeleMAT program. The state should provide direct reimbursement to universities for continuation of the ECHO programs.**
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
    - **OKPCA: OHCA could contract directly with ACOs for a shared savings arrangement through an ACO track that is separate from the MCO track. Additionally, OHCA can require MCOs to contract with ACOs. OHCA could require MCOs to allow for reimbursement of preventative services without prior authorizations and to offer provider incentives and pay for performance measures for demonstrating improved health outcomes.**
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?
    - **OKPCA: Yes, as appropriate.**

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes
- MCOs will reimburse providers using a methodology with a performance-based component that incentivizes outcomes for state-priority conditions
- OHCA is investigating the use of incentive measures, quality pools and other programs; MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?
    - **OKPCA: OHCA should require MCOs to contract with ACOs and other clinically integrated networks who have demonstrated success in utilizing population health to improve health outcomes and contain costs.**
- What are the most important indicators of MCO performance? Why?
    - **OKPCA: Improved health outcomes of patients, provider retention and satisfaction and reinvestment of cost savings into program enhancements.**
- What measures of health outcomes should be tracked? Develop outcomes to measure the above identified population health goals
    - **OKPCA: Examples include percent of patients screened for tobacco and SBIRT and percent of patients referred for follow up services related to a positive screen.**

<u>Care Management and Coordination</u>

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management

requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- Conduct health screenings to identify ongoing need, current providers, and social determinants of health
- Develop care plans for identified enrollees and establish care management and care coordination based on identified risk and particular health conditions
- Design health management programs with a holistic approach to member health
- Conduct health education in priority areas and on emerging issues

In addition, MCOs will support Patient Centered Medical Homes under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

- OKPCA: Require plans to pay an enhanced rate to provider agencies who are certified through NCQA in PCMH.
- OKPCA: Require plans to pay an enhanced rate to provider agencies who are certified in trauma informed care

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
    - **OKPCA: By encouraging plans to utilize data extraction tools and limiting provider requirements that increase administrative burden.**
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
    - **OKPCA: Require MCOs to contract with and reimburse all LBHPs and disallow them to from limiting participation by only LCSWs or Psychologists. Require MCOs to allow for "organizational delegate credentialing" of safety net providers such as FQHCs, RHCs, CCBHCs and CMHCs if the safety net provider is capable**

of administering such delegation to allow for these organizations to continue to utilize providers who are under supervision for licensure as part of care delivery network and to allow them to credential their own providers rather than requiring them to credential each provider with each MCO – instead, the MCO would credential the organization and the organization would credential their employed and contracted providers.

- How can MCOs improve the management and coordination for members with chronic or complex health conditions?
    - **OKPCA: Require plans to reimburse for case management and care coordination services and to pay an enhanced rate for agencies that are certified through NCQA in PCMH. Also, MCOs should contract with and incentivize ACOs and other clinically integrated provider networks with demonstrated experience and success in managing chronic and complex health conditions.**
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?
    - **OKPCA: From the outset require plan participation in the BHAC (Behavioral Health Advisory Council). Reinstitute the annual OHCA strategic planning retreat and invite these important stakeholders to participate.**

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- Answer member questions timely via telephone or email and resolve grievances and appeals timely
- Frequently update provider directories online to help members locate health care providers
- Provide member materials in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs? By incentivizing providers who utilize technology to improve health outcomes.
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service? Offer member's "locked down" iPads or tablets that they can use to connect with their providers.
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
    - **OKPCA: By having a secure site where members can post feedback and suggestions on program and plan improvements. By having a Consumer Advisory Council made up of plan participants that all plans and subcontractors are required to participate in and that informs the DUR, the MAC and the OHCA Board.**
- What tools and resources would help members search for providers? What information should be provided?
    - **OKPCA: Require all participating MCOs to contract with all FQHCs and safety net providers and require all plans to post updated in-network providers on the OHCA website and require them to include information on whether the provider is accepting new Medicaid patients and to list the populations that they serve (for example, infants, children, adolescents, adults, older adults). Additionally, OHCA could maintain this function by listing all participating providers and including all of the same information just described as well as identifying which MCOs the provider is "in network" for.**

<u>Provider Payments and Services</u>

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed

    - **OKPCA: RFP should require that all FQHCs must be paid under a PPS or under an APM that is agreed to by both the MCO and the FQHC and that could not result in the FQHC being paid less than it would receive under PPS, as required through the SSA. *See cover letter for suggested language and requirements.**
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
    - **OKPCA: Make this same requirement apply to FQHCs, RHCs and CCBHCs.**
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
    - **OKPCA: Make this same requirement apply to FQHCs, RHCs and CCBHCs.**

- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
    - **OKPCA: Require plans to offer "organizational delegate credentialing" to FQHCs, RHCs, CCBHCs and CMHCs. The MCO credentials the organization/agency/site but the organization is then allowed to credential its own providers – this decreases the administrative burden by not requiring the organization to have to credential each of their providers with each MCO—instead, the MCO would credential the organization, and the organization would credential their employed and contracted providers.**
    -
- Maintain and/or expand telehealth availability
    - **OKPCA: Require MCOs to reimburse the PPS encounter rate for telehealth services provided by safety net providers such as FQHCs, RHCs and CCBHCs.**

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?
    - **OKPCA: RFP should require that all FQHCs must be paid under a PPS or under an APM that is agreed to by both the MCO and the FQHC and that**

could not result in the FQHC being paid less than it would receive under PPS, as required through the SSA. *See cover letter for suggested language and requirements.

- What is appropriate for timely payment of claims?
    - **OKPCA: OHCA reimburses claims in 14 days—a similar period would be preferable for timely billing and receipt.**
- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?
- How can MCOs best communicate to providers about updates and changes to plan policies?
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes? Require MCOs to share claims data with the HIE and to contract with ACOs and other clinically integrated networks and to share claims data with these participating provider networks in a timely manner to allow providers to coordinate care and services and manage utilization of high cost patients. OHCA could offer a separate ACO track where they contract directly with ACOs through shared savings arrangements.
- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?
    - **OKPCA: Same as previous answer plus require MCOs to educate providers in the Quadruple Aim and how ACEs (Adverse Childhood Experiences) drive negative health and behavioral health outcomes and offer incentives to organizations who train their providers in trauma-informed care.**

<u>Network Adequacy</u>

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

- Examples of industry standards include:
    - Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care

    - Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
    - Require all Primary Care Providers have at least some same-day acute care appointments
    - Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)
        - OKPCA: Require plans to allow for and reimburse OSU ECHO programs for access to specialty care.

- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?
- What are reasonable time and distance standards in Oklahoma by provider type?
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?
    - **OKPCA: Encourage Oklahoma Health Plans to offer provider incentives to specialists who agree to see at least some Medicaid patients.**
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?
    - **OKPCA: Require plans to allow for and reimburse OSU ECHO programs for access to specialty care. Require MCOs to allow for "organizational delegate credentialing" by safety-net providers so that they can continue to utilize providers "under supervision" while completing their training and licensure requirements.**

<u>Grievances and Appeals</u>

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?
- How can the state and MCOs use appeals data to improve utilization management and access?
    - **OKPCA: By looking for trends and requiring plans to track and address commonalities in appeals by modifying policies and procedures to address identified areas of concern (for example, if a plan has multiple appeals for a specific prior authorization requirement that are most often turned over on appeal, the plan should be required to look at adjusting the related prior authorization requirement).**

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- Gain accreditation by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- Maintain an Oklahoma presence, including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- Participate in the state Health Information Exchange to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans
    - **OKPCA: Have plans require all providers to participate in HIE reporting as a condition to network participation. Assess plans and providers a penalty for not reporting.**

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?
    - **OKPCA: Have plans require all providers to participate in HIE reporting as a condition to network participation. Assess plans and providers a penalty for not reporting.**
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?
    - **OKPCA: Through utilization of ACOs and clinically integrated provider networks. MCOs should be required to share claims and utilization data with these type of participating providers in "real time" so that the data can be used to coordinate and manage the patients care.**
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?
    - **OKPCA: Not necessarily as some MCOs might want to specialize in serving the Medicaid population. Additionally, requiring this upfront would cause them to focus some of their efforts and attention on developing this additional service line and it would take focus and attention away from the SoonerCare program development and implementation. For future years, you could incentivize plans to participate by offering them bonus points on their RFP response for participation in the Oklahoma Health Insurance Marketplace.**

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August 21, 2020

RE: SoonerCare Comprehensive Managed Care Program (80720200002)

Oklahoma Primary Care Association is the statewide association of community health centers. Community health centers are largely private, nonprofit organizations supported by multiple resources including private contributions, public grants, and operational revenues. As health centers, these entities, by law, must serve designated Medically Underserved Areas or Populations. The design of community health centers is to overcome patients' barriers to accessing primary medical care and achieve increased wellness. Services provided are often broader than primary care alone and include mental health and addiction recovery, dental, pharmacy and other services integrated in the practice based on each particular community's unique needs.

Health centers must serve all persons regardless of income, geography, or health insurance coverage. Health centers that meet federal requirements to be eligible for health center grants from the Bureau of Primary Health Care, whether or not they are grant recipients, are eligible to be separately deemed by the Centers for Medicare and Medicaid Services as federally qualified health centers (FQHCs) which provides different reimbursement mechanisms for the provision of services to Medicare and Medicaid patients. All community health centers in Oklahoma are deemed FQHCs and are commonly identified by that designation; however, other types of entities may also be deemed as FQHCs. Therefore, hereafter, we refer to these entities as "heath centers."

Oklahoma Primary Care Association members collectively would prefer that the State not enter arrangements to manage Medicaid by third-party out-of-state Managed Care Organizations (MCO) for multiple reasons. In lieu of such an arrangement, the Association would rather the State pursue an improved design of the Patient Centered Medical Home (PCMH) model currently managed by the agency and redirect the costs of third-party administration for eligible patient services and for increasing provider incentives through value based payment methodologies, such as pay for performance and shared savings arrangements, based upon improved quality outcomes and increased cost containments. We agree that Oklahoma must both responsibly and efficiently steward Medicaid resources and pursue the best possible means to ensure the provision of high quality health care for Medicaid members in a manner that effectively results in improved health outcomes. Further, we agree with the stated overarching goals in the request for public feedback design: improving health outcomes, moving to value-based payment, improving member satisfaction, and containing costs. These are goals that health centers deliberately and thoughtfully include in their daily operations individually and mutually. Presuming that the State continues to pursue third-party MCO arrangements, the Association responds with the following requests specific to the provision of health center services.

FQHC Prospective Payment System as a Minimum Payment

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 provides that FQHC-deemed health centers will, at minimum, be paid at a rate equal to 100 percent of each health center's average reasonable costs of providing Medicaid services paid on a per patient encounter basis. This average is calculated from the costs of a base year divided by the number of patients encounters, paid thereafter, annually adjusted for inflation based on the Medicare Economic Index, and subsequently taking into account any change in the scope of services furnished. This is known as the FQHC prospective payment system or PPS. The prospective per encounter rate is effectively a full-risk, bundled payment. The prospective rate paid is based on an historical average and remains constant for every encounter during a

fiscal year regardless of whether the true costs for providing the collective services of a patient encounter exceed that average. Accordingly, health centers are incentivized to be judicious in the provision of services so that the average of the sum of costs of the majority of Medicaid patient encounters do not exceed that PPS rate which would result in a net loss to the health center. Within the bounds of health center scope of services, this method supports the OHCA goal of creating predictable costs for the State. MCOs must also demonstrate that FQHCs are paid at least what non-FQHC providers in their network for the same medical services are paid (§ 1903(m)(2)(A)(ix) of the Act).

Alternative Payment Methods

Within the federal law that provides for Medicaid FQHC PPS, there is also a provision for alternative payment methods (APMs) for FQHC services. Within that policy for health centers, an APM must:

- Result in a net payment that is at least equal to what the health center would have been paid under Medicaid FQHC PPS;
- Be agreed to between each individual health center and the State (The APM does not require universal participation);
- Be described in the approved State plan.

There is great flexibility and opportunity for design and meeting mutual goals with the option of APMs. For example, if there are particular care coordination services and connected patient outcome goals that that State would like to pursue, the State may offer a health center an incentive payment to provide such services as may yield yet further improved health outcomes and resulting cost savings. Similarly, with patient attribution data and information about patient behaviors across providers, a health center and the state may develop a capitated payment mechanism with the possibility of additional shared savings for achieving identified mutual goals.

FQHC Prospective Payment System Wrap Around

Maintaining appropriate cash flow by timely payments is critically important to achieving shared goals for health centers with already narrow margins. Under federal Medicaid managed care policy, the State must pay any difference between the total payments from a managed care corporation and an amount that a health center would have otherwise collected in PPS payments for the provision of services in accordance with an agreed upon schedule but in no case less than every four months – our request is that language be put in to the RFP requiring these payments be made monthly. Without such provision, health centers could be without a portion of payments for some time compared to direct payment for PPS eligible services outside of MCO arrangements. A four-month delay in a portion of payments due is potentially detrimental to the shared goal of improved patient outcomes because it could restrict the capacity of health centers to provide the timely preventive and primary care services for Medicaid members in already Medically Underserved Areas. The potential for this is highlighted by the fact that Medicaid enrolled patients—especially with newly eligible members—constitute a substantial portion of most health center patient populations. Further, that additional layer in making payments requires more administrative work (and therefore added cost) than the current process. We urge the State to ensure that there is a mechanism for more timely payment reconciliation.

We recommend including in the state's RFP the statutory requirements at section 1902(bb) of the Social Security Act (Act) that all FQHC services shall not be paid less than the PPS rate (or APM amount) for each encounter. The PPS may be paid by the MCO through the capitation rate or other form of payment plus a wrap around payment from the State that together equal the PPS rate. We further request that the RFP ensures that MCOs and the State have a mutually agreed upon data sharing arrangement providing for timely calculation of wrap around payments due that minimizes overall payment delays and that ensures that data is collected to construct what would constitute PPS-eligible patient encounters outside of a differing MCO payment mechanism.

In the event that payments are to be made to health centers by MCOs with subsequent wrap around payments, we request that the RFP include a comparability clause which ensures that payments to health centers from MCOs would be at least equal to the amount of payment that the MCO would pay for services if rendered by a provider that is not part of an FQHC, and that contracts between MCOs and health centers include a provision accordingly that the MCO represents that payments to health centers are no less than they otherwise would pay to other providers for the service. This would provide for health centers to have improved short term revenues and not burden the State with increased costs due to significant underpayments from an MCO who takes advantage of the State being required to pay a wrap around to FQHCs to PPS equivalent amounts.

APM with Incentive Payments

In an FQHC APM that includes incentive payments, we again reiterate that PPS is designed to be a payment floor, not a ceiling, such that APMs with FQHCs must include that the payments in total are at least what they would have been under PPS. Accordingly, in the event that an APM is entered into with incentive payments, such incentives are not to effectively be removed in the wrap around calculation process. The Centers for Medicare and Medicaid Services (CMS) has long held that incentive amounts are separate from the MCO's payment for services and should not be included in Medicaid's calculation of supplemental payments. Writing in 2016 in response to a Medicaid managed care final rule, the agency affirmed that positive financial incentives paid by MCOs allow FQHCs to earn revenue over and above the amounts required under the PPS reimbursement methodology, writing, "In the event a particular financial incentive arrangement related to meeting specified performance metrics for these providers is part of the provider agreement with the managed care plan, those financial incentives must be in addition to the required reimbursement levels specified in the State plan." Similar guidance was provided by, then, Health Care Financing Administration to States in September 2000.

Ensure Health Center Network Participation

Health centers are essential community providers and are especially qualified to best meet the unique needs of underserved Medicaid recipients. Both by law and by mission, health centers are structured to address the myriad of chronic physical and behavioral health issues often present in low-income Medicaid recipients. Plans selected to manage the health of Oklahoma Medicaid beneficiaries should be required to offer contracts to all FQHCs and to inform their members that they are eligible to get services at the FQHCs without prior authorization. Further, beneficiaries should be able to choose the entire FQHC as the PCP instead of selecting one specific individual provider in order to reduce administrative barriers to FQHC services – if this is not possible, FQHCs should be allowed for available FQHC providers to provide services to the patient in place of the patients PCP without penalty to the FQHC or the patient. Additionally, we request that all FQHCs be given access to Agency View to assist eligible enrollees with the application process. We also request that OHCA work with FQHCs, prior to MCO program implementation, to establish a process for auto-assigning our existing patients to an MCO that we are contracted with and to assigning the patients existing health center and/or health center provider as their PCP (for example, health centers could submit a file of existing Medicaid patients with current provider to OHCA).

Additionally, FQHCs frequently see patients with urgent, unforeseen health concerns that require immediate attention. FQHCs have an obligation to treat these patients— even if the patient is a Medicaid recipient enrolled in a Medicaid MCO with which the FQHC is not a participating provider. The FQHC is nonetheless entitled to full payment through either the MCO or through direct payment from the state to the FQHC for these services. We again recommend that MCOs bear this payment responsibility in order to decrease administrative complications for the State.

Improving Health Outcomes & Containing Costs

The value delivered by health centers has been confirmed by studies showing that health center patients have lower overall costs to Medicaid by successfully reducing avoidable specialty and hospital services. Health centers have demonstrated success in achieving quality metrics and

improving patient care in the Medicaid program and should be looked to as valued partners in our shared goals of improving health outcomes and managing costs. Oklahoma Primary Care Association stands ready to assist health centers and the State as OHCA considers proposals to increase access to care and improve system accountability in the Medicaid program.

We appreciate this opportunity to provide input and feedback regarding the design of this program and should OHCA be directed to move forward with the implementation of this program, we look forward to working with OHCA and the participating MCOs to ensure the success of the program's system reform goals, the protection and success of our FQHC and other safety-net providers and improved health outcomes for all Oklahomans. To ensure this, in addition to the feedback provided in this letter, we have provided responses to some of the specific questions put forth in the request for public feedback in program design (attached with responses to specific questions highlighted for convenience). For questions regarding these comments or for additional supporting information, please feel free to contact me by phone or text at (405) 388-0900 or by email at sbarry@okpca.org.

Respectfully,

Sara Barry, M.Ed., LBP
CEO, Oklahoma Primary Care Association

August 13, 2020

Oklahoma Health Care Authority (OKHC)
SoonerCare Comprehensive Managed Care Program

RE: Public Feedback in Program Design #80720200002

Dear OKHC Procurement,

Finity is pleased to present our feedback regarding your request for proposal for the SoonerCare Comprehensive Managed Care Program. Our feedback is specifically in response to the following enrollee question: "How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?"

Thank you for the opportunity to provide our feedback on the following pages of this document.

Sincerely,

Alexandra MacDonald, Chief Client Officer
amacdonald@finity.com
503-830-4239

Finity's Health Engagement Recommendations for SoonerCare

Finity Background

Finity is the leading health engagement company in the country. We serve millions of people nationwide through health plans, hospital systems, State Medicaid agencies, providers, and the Centers for Medicare and Medicaid Services (CMS). Our mission is to empower individuals to make conscious, healthy decisions that improve their health and wellbeing.

Finity's Experience with Statewide Medicaid Population Health Engagement

In 2013, Finity partnered with the New Mexico Human Services Department (HSD) to launch the first Medicaid statewide population health engagement solution in the country. The vision of this program was to provide a statewide health engagement solution that was portable among Managed Care Organizations (MCOs), improved the health of Medicaid beneficiaries, improved quality scores, improved HRA participation and generated cost savings. To achieve this vision, HSD included program language in its initial Section 1115 demonstration waiver, which was approved by CMS for federal match funding. HSD worked with MCOs to select a single vendor to administer the program and included program language in the MCO contracts. Finity was selected and has run the program successfully since January 2014, with governance for the program including representation of HSD staff and supported by champions from each MCO. HSD expanded the program in 2019 when its 1115 waiver was renewed for five years by CMS.

Proven Results through Portable Statewide Health Engagement Solution

The New Mexico Medicaid Health Engagement Program is the only statewide population health engagement solution in the country with a proven significant cost savings—more than $200M over six years. Between 2014 and 2019, participation has grown to over **71%** of New Mexico Medicaid beneficiaries. It has resulted in the most effective ways to communicate to Medicaid beneficiaries. It has improved health outcomes, improved HEDIS compliance, and lowered costs for participants vs. nonparticipants. Additional results include:

- **Increased rates of preventive services and medication refills** for participants and lower inpatient utilization, which decreases statewide Medicaid medical spend.
- **Improved HEDIS measure compliance in all core activities**.
- **14% improvement in obtaining current addresses and phone numbers,** which increases the savings via reduced returned mail costs and increased call connection rates for all MCOs.
- **95% member satisfaction** rate.
- Over **71% participation** at a State-level.

Centennial Rewards Cost Savings by Activity 2014-2019[1]

Condition or Activity	Average Savings PMPM	Total Six-Year Savings (in Millions)
Adult PCP Visit	$39	**$28.5**
Asthma	$21	**$11.9**
Bipolar	$18	**$14.8**
Bone Density	$200	**$6.1**
Diabetes	$27	**$56.0**
Perinatal	$90	**$9.7**
Schizophrenia*	$72	**$9.9**
Well-Baby Visit	$43	**$15.1**
Step-Up	$38	**$12.5**
HRA Completion*	$12	**$36.6**
Six-Year Total Cost-Savings Total		**$201,100,000**

***** For years in which cost savings were found.

Cost-Savings Methodology

As directed by CMS, Finity calculates cost-savings by comparing the medical costs of program participants to nonparticipants annually.

- Participants are defined as members who complete at least one reward activity and have been "actively" engaged in the program.
- A weighted "one-to-many" matching is used to match each participant to a nonparticipant on a variety of factors including age, gender, risk scores, chronic conditions, and more.

Then the total medical spend for both groups is compared using linear regression models, and the difference is the cost savings.

Recommendations for Oklahoma's SoonerCare Comprehensive Managed Care Program

Based on our proven results with New Mexico's Medicaid population over the past six years, we recommend the following strategies and program components to help SoonerCare MCOs better engage individuals in their health care and healthy behaviors.

- Implement a state-run member engagement program to both engage and incentivize members to participate in healthy behaviors such as preventive screenings, medication management, prenatal and postpartum visits, wellness challenges (e.g., nutrition, physical activity, tobacco cessation), condition management visits/tests, well-child visits, and completion of an assessment to address health and SDOH risks.
    - Research shows that programs must put an emphasis on consistent engagement through multiple forms of media to be successful in creating behavior change.[2]

[1] Finity Communications, Inc. *Centennial Rewards: Year 6 Annual Report.* July 2020.

[2] Vulimiri M, WK Bleser, RS Saunders, et al: Engaging beneficiaries in Medicaid programs that incentivize health-promoting behaviors. Health aff (Millwood). Mar;38(3):431-439, 2019. doi: 10.1377/hlthaff.2018.05427.

- Ongoing multimedia engagement coupled with targeted, gamified incentives to reward desired behavior change positively reinforces members to continue demonstrating healthy behaviors. This leads to improved health outcomes, such as decreased inpatient admission rates, improved HEDIS rates, and higher rates of compliance by high-risk members, which decrease overall medical spend and generate cost-savings.
- Research also shows that engagement programs that include incentives for completing health activities, including screenings and care for chronic conditions, can increase health engagement and help close gaps in care.[3]
- Recommended engagement program components include:
    - **Statewide Whole Person Assessment (WPA)** that extends a traditional health risk assessment to meet whole person needs, including SDOH, readiness to change, financial, and employment needs.
        - Integrate within the SoonerCare Enrollment system to **generate 100% completion rate** and identify high-risk members pre-claim.
        - Provide your most vulnerable population with transportation, food, housing, and more resources and support from Day 1 based on personalized WPA output.
        - Increase ROI by eliminating costly outbound outreach by MCOs to administer the HRA.
        - Simple addition to your existing eligibility system that would save the state over $10M per year in existing HRA costs.
        - Provides the State with deep analytic insights into the health, SDOH, and engagement issues of their population.
    - **A responsive member web portal with personalized health, wellness, and SDOH "LifeTracks"** to improve population health and quality compliance using targeted multimedia engagement and points-based incentives.
        - Place members on personalized LifeTracks that provide wellness, condition management, and SDOH tools and resources to support each member's holistic health and wellbeing based on WPA results.
        - Engage members in LifeTrack activities that improve quality measures, wellness, and condition management.
        - Key quality improvement measures should be managed at a State-level so that federal dollars are used for member engagement.
        - Tailor engagement campaigns and incentives to the State's needs and goals. This will typically include HEDIS-driven activities that generate cost savings such as well-care visits and perinatal care, and wellness challenges that promote overall health and build healthy habits, leading to lower utilization and reduced cost of care.

[3] Van Vleet, Amanda and Robin Rudowitz. "An Overview of Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Grants." KFF.org. http://kff.org/report-section/an-overview-of-medicaid-incentives-for-the-prevention-of-chronic-diseases-issue-brief-mipcd-grants. September 16, 2014. Accessed January 9, 2020.

- **Multimedia engagement delivery and tracking** including text, email, web, print, inbound and outbound calls, video, and social media.
- **Comprehensive peer health coaching and support for high-risk pregnancy and diabetes** that uses smart biometric device integration to maximize engagement and lower costs.
- **Telehealth member readiness support** and IT troubleshooting to remove barriers and engage members in virtual care.

Final Thoughts

Implementing a statewide member engagement program is the best way to communicate with your Medicaid members. Based on our experience with other state Medicaid programs, a statewide engagement program achieves higher participation rates, as high as 72% participation. That is significantly higher than any individual engagement program run by any health plan in the country. The member engagement program will drive member quality compliance for the MCOs and the state. By establishing a statewide member engagement program, the data is portable among MCOs and you leverage federal funding, drive population health improvement, and achieve consistent data and reporting for comparison across MCOs. Following the proven New Mexico Medicaid model, we recommend including statewide member engagement program language in both the MCO RFP and contracts. We also recommend including engagement program language in your next Section 1115 demonstration waiver renewal to garner federal funding. We are happy to discuss any of these recommendations and strategies at your convenience and appreciate the opportunity to provide our feedback.

August 17, 2020

VIA ELECTRONIC SUBMISSION

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
procurement@OKHC.org **VIA EMAIL**

Re: Request for Information – SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

Dear Sir/Madam:

On behalf of the National Health Law Program (NHeLP), we appreciate the opportunity to provide these comments on Oklahoma's planned Comprehensive Medicaid Managed Care Implementation. Founded in 1969, NHeLP protects and advances the health rights of low-income and underserved individuals. We advocate, educate, and litigate at the federal and state levels to advance health and civil rights in the U.S.

NHeLP has worked with Medicaid managed care for decades, engaging in studying, analyzing, training on, and litigating Medicaid managed care issues. We have monitored the development of many comprehensive managed care systems around the country. Based on our knowledge of the evolution of these systems, as well as the past difficulties Oklahoma has previously faced in attempting to transition to capitated managed care, we strongly recommend that you do not pursue this implementation plan. At the very least, the timetable you have proposed is unworkable and attempting to make such profound changes in this short period of time is likely to harm beneficiaries and become mired in administrative challenges.

I. Concerns about capitated managed care

The State hopes that implementing managed care will "improve health outcomes, increase access to care, and increase system accountability," as well as containing costs in the Medicaid program. Okla. Health Care Auth. SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design, http://okhca.org/mco/. Managed care, however, does not necessarily advance those goals and can undermine them. In fact, capitated, for-profit managed care in Medicaid can result in significant waste of public money on administrative costs and plan profits. It can also result in poorer quality care. Nor does it guarantee accountability. States that have managed care systems continue to make improper, unnecessary payment and must monitor and audit extensively to uncover these problems.

Problems with quality of and access to care.

Commercial plans not only have an incentive to make profits, they have legal and fiduciary obligations to shareholders to maximize them. This creates a powerful incentive to limit even medically necessary services and disenroll Medicaid beneficiaries with high needs. The federal Medicaid and CHIP Payment and Access Commission (MACPAC) has recognized this risk, citing studies indicating that capitation may "create incentives to undertreat patients to minimize costs.[1] Concerns about problems with Medicaid MCOs denying access to requested services has led the the Office of Inspector General at the U.S. Department of Health and Human Services (HHS OIG) to investigate access problems.[2]

One of the major problems in Medicaid is the lack of available providers. This is true of managed care. A recent study of provider availability in Medicaid managed care from the HHS OIG found that slightly more than half of enrolled Medicaid providers were not able to offer appointments to enrollees, leading to long wait times and overall lack of access to services.[3]

A lack of support from the Medicaid provider community would make it even more difficult to implement managed care successfully, and it is not clear that OHCA and the administration have had time to build this support. Other states have had trouble without the support of providers. For example, California's Medicaid agency had difficulty recruiting providers for its recent managed care expansion because the providers were unwilling to move from fee-for-service to a capitated system. Some were accustomed to serving non-disabled mothers and children with lower needs and were reluctant to assume the risk for serving higher needs populations.[4] And, after Tennessee launched its capitated managed care system, the Tennessee Medical Association sued the

Medicaid agency, alleging violations of federal and state law provisions governing payment rates.[5]

No Cost Savings/Risk of Improper Payments

It is far from clear that capitated managed care actually saves money. Peer-reviewed studies suggest that any state savings are not significant, particularly when provider reimbursement rates are already low.[6] For example, one study of adults with disabilities found no association between MCO programs and lower Medicaid spending. It found that average, total, per beneficiary Medicaid expenditures did not differ between fee-for-service and MCO programs.[7] Another study found that shifting Medicaid recipients from fee-for-service into managed care did not reduce Medicaid spending in the typical state. Savings were only realized in states that had high Medicaid reimbursement rates that could be reduced by the switch to managed care.[8]

And, despite the substantial regulatory and monitoring efforts devoted to oversight by states and the federal government, there is still a high risk of improper payments in managed care. The federal Government Accountability Office (GAO) has devoted substantial resources to studying this problem. Some examples of the state audits that identified overpayments and unallowable costs include the following:

- The Washington State Auditor's Office found that two managed care organizations made $17.5 million in overpayments to providers in 2010, which may have increased the state's 2013 capitation rates.
- The Texas State Auditor's Office found that one managed care organization reported $3.8 million in unallowable costs for advertising, company events, gifts, and stock options, along with $34 million in other questionable costs in 2015.
- The New York State Comptroller found that two managed care organizations paid over $6.6 million to excluded and deceased providers from 2011 through 2014.[9]

Administrative Burdens

Ensuring program integrity is challenging, requiring states to expend resources in setting up administration and conducting monitoring. This is particularly true in managed care, yet it is extremely important to ensure that funds are being expended consistent with the law, as the discussion of overpayments indicates above. As the GAO has observed, oversight in Medicaid can be "challenging, given its size and

complexity," designating Medicaid as a "high risk" government area, and specifically identifying Medicaid managed care "risks related to … state MCO payments and risks with payments from MCOs to providers.")[10]

There are numerous examples of for-profit managed care plans engaging in profiteering, or even fraud. For example:

- In 2007, Amerigroup Illinois was found liable under the federal False Claims Act (FCA). A jury found that the MCO obtained Medicaid contracts by falsely promising that they would not discriminate based on need for health services and that they submitted false claims for payment in the form of enrollment applications containing false certifications. It awarded $ 48 million in damages for these misrepresentations.[11]
- In 2011, the Florida Medicaid agency issued more than $6 million in fines against HMOs. For example, it fined Amerigroup Florida $2,655,000 for allegedly denying medically necessary speech therapy services to hundreds of Medicaid-eligible children. The agency also fined Humana more than $3 million for failing to promptly report Medicaid fraud and abuse to state investigators.[12] In addition, Amerigroup received nearly $15.7 million in state funds to provide mental health services. Auditors were able to account for only $10.4 million in expenses.[13]
- A false claims action was filed again Florida-based HMO WellCare, alleging that their actions defrauded Florida's Medicaid program of as much as $400 million. That suit was ultimately settled with Florida receiving only $54 million.[14]
- In 2005, Florida's Medicaid program operated a pilot program through which it enrolled children in prepaid, for-profit dental plans. The number of children who received dental care through the Medicaid program dropped 40% during the first year of the pilot. One HMO, Atlantic Dental, was paid more than $20,000 to provide care for nearly 800 children, but provided care to only 45. A study showed that Florida paid $15.3 million for services worth only $2.1 million. In the previous year, in the fee for service system, the value of services provided was $15.9.[15]

And, as OHCA has experienced, managed care plans can fail or withdraw, causing expense and disruption and making it difficult to track quality measures from year to year or between plans:

- In 2012, DC's Chartered Health Plan was placed in receivership. It is estimated that the plan owed participating providers as much as $85 million in unpaid claims, but had only about $15 million in liquid assets. The DC government has agreed to pay participating providers $18 million on their unpaid claims. The balance of the claims were paid by an emergency grant program funded by DC's contingency cash fund. [16]
- Kentucky's Medicaid program was thrown in disarray as a result of the withdrawal of one of its Medicaid HMOs. Kentucky Health Spirit, a subsidiary of Centene, had a risk-based contract to provide acute care and pharmacy services for about 125,000 beneficiaries through 2014. In 2013, the HMO announced its plan to withdraw early from the contract. Its spokesman claimed that the capitated rates were inadequate and had been based on bad data. The executive vice president of operations for Centene stated that "we do not believe there is a viable path to a sustainable managed care program in Kentucky."[17]
- Tennessee saw two of its for-profit Medicaid MCOs abruptly withdraw from the Medicaid program, causing great expense and turmoil. In 1999, HMO Xanthus became insolvent and went into receivership. Access MedPlus suffered a "premature collapse" in October 2001, forcing the state to shift nearly 280 thousand beneficiaries into another plan.[18] Thus, the state was left with the choice of paying substantial unpaid provider claims or facing significant negative publicity and political consequences. A detailed description of the struggles Tennessee has faced with managed care, including loss of millions of dollars, can be found here.

We urge you to give careful consideration to the potential problems that can accompany capitated, for-profit managed care. Evidence and examples from around the country illustrate how problematic for-profit managed care can be, and how it can waste money, serve beneficiaries poorly and cause major headaches for the state Medicaid agency.

II. OHCA's timeline is extremely unrealistic

OHCA has announced that the transformed system will be implemented on October 1, 2021. Yet, the RFPs for the plans will not be released until sometime this fall. That leaves just 14 months to consider comments, draft the RFP, evaluate responses, select plans, set capitated rates, design and select quality and performance measures, formulate the healthy behavior incentives, decide whether to have separate plans for specialty populations, and put in place all the administration and personnel necessary to make this system operational. It defies reason to think that all of this can be done – and done well – in the time allotted, particularly when the state also has to deal with the COVID-19 health emergency.

Experience has shown that rushing the launch of managed care, particularly when enrolling people with disabilities, leads to serious problems. For example, a study showed that when California's Medicaid program transitioned 240,000 older people and people with disabilities to capitated managed care in a very short time period, beneficiaries encountered multiple problems: [19]

- The agency had difficulty recruiting primary care and specialty providers with sufficient expertise to serve this population. One of the main barriers to building adequate networks was the unwillingness of providers to join plan networks.
- The agency failed to inform thousands of beneficiaries of the transition of managed care, leading to confusion and barriers to obtaining treatment.
- The agency did not have accurate data about enrollees' health and prescription history, making it more difficult for providers to effectively care for patients.
- Providers provided unreimbursed care during the transition in order to prevent harmful disruptions in care.
- Plans complained that capitation rates were not adequate, because of failure to account for the higher needs of the population.
- Despite the fact that one of the primary goals of the transition to managed care was care coordination, providers reported that their time was taken up with obtaining authorizations and appealing denials, leaving no time for care coordination.

III. Conclusion

State Medicaid agencies are ultimately responsible for compliance with the Medicaid Act, and ensuring that MCOs comply as well. A federal Court of Appeals affirmed the fundamental legal principle that the state Medicaid agency has the ultimate burden of ensuring compliance with all Medicaid requirements and "cannot evade federal requirements by deferring to the actions of other entities."[20] This decision is consistent with rulings from other courts. Other federal courts have recognized that "it is patently irresponsible to presume that Congress would permit a state to disclaim federal responsibility by contracting away its obligation to a private entity."[21] The District Court for Arizona held that actions taken by independent managed care authorities to suspend and reduce services were state actions because they were made on behalf of the government.[22] In sum, the obligations to comply with federal Medicaid requirements ultimately remains with the state, thus Oklahoma will have the obligation and additional burden of monitoring the managed care plans and holding them accountable. This is a heavy burden for a state that becomes much more complicated when it contracts with MCOs. Oklahoma has already had two failed attempts to implement risk-based managed care. Thus, the state should proceed slowly and deliberately in assessing whether it is advisable at that time to transform the system to a risk-based managed care system, with transparency and openness to all the stakeholders in the Medicaid program.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Sarah Somers (somers@healthlaw.org).

Sincerely,

Sarah Somers,
Managing Attorney

[1] MACPAC, Managed Care's Effect on Outcomes, https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/ (noting the incentives to restrict access to care and compiling research).

[2] U.S. Dep't of Health & Human Servs., Office of the Inspector General, Medicaid Managed Care Organization Denials (Review Pending), https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000370.asp, (last visited Aug. 17, 2020).

[3] U.S. Dep't of Health & Human Servs., Office of the Inspector General, *Access to Care: Provider Availability in Medicaid Managed Care* (Dec. 2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

[4] Kaiser Commission on Medicaid and the Uninsured, *Issue Brief: Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California* (June 2013), available at http://kff.org/medicaid/issue-brief/transitioning-beneficiaries-with-complex-care-needs-to-medicaid-managed-care-insights-from-california/.

[5] *Tennessee Medical Ass'n v. Corker,* No. 01-A-01-9410-CH00494 (Tenn. Ct. App.).

[6] Sarah Goodell and Michael Sparer, *Medicaid Managed Care: Costs, Access, and Quality of Care* (Sept. 2012), available at www.policysynthesis.org.

[7] Marguerite E. Burns, *Medicaid Managed Care and Cost Containment in the Adult Disabled Population,* 10 MEDICAL CARE 1069 (Oct. 2009).

[8] Mark Duggan and Tamara Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates* 32 J. Pol'y and Mgmt. 505 (March 2013).

[9] Government Accountability Office, *Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks* at 10-11 (June 2018), https://www.gao.gov/assets/700/692821.pdf; *See also* Government Accountability Office, *High Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas* (Mar. 2019), https://www.gao.gov/assets/700/697245.pdf; Government Accountability Office, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks* (July 2018), https://www.gao.gov/assets/700/693418.pdf.

[10] Government Accountability Office, *Medicaid - High Risk Issue*, https://www.gao.gov/key_issues/medicaid_financing_access_integrity/issue_summary (last

accessed Dec. 23, 2019). *See also* Government Accountability Office, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care* (May 2018), https://www.gao.gov/assets/700/691619.pdf; (reporting results of state audits finding millions of improper and wasteful payments, including payments of capitated rates for deceased or ineligible beneficiaries or for fraudulent claims).

[11] *United States ex rel. Tyson v. Amerigroup Ill., Inc*., 488 F. Supp. 2d 719, (N.D. Ill. 2007).

[12] Letter from Sue Conte, Bureau Chief, Managed Care Bureau, Florida Agency for Health Care Admin. to Don Gilmore, Chief Operating Officer, AmeriGroup Community Care (Dec. 21, 2010); *see also* Dina Overland, *HMO Fined $4M for Denial of Services,* FIERCE HEALTHPAYER (Jan. 13, 2011), *available at* http://www.fiercehealthpayer.com/story/hmos-fined-4m-denial-services/2011-01-13. *See also* Seventh Amended Complaint, U.S.A., et al., v. Wellcare Health Plans, Inc., et al., (M.D. Fla. June 10, 2013) (Case No. 8:06-CV-01079T-30TGW).

[13] Jim Saunders and Carol Gentry, *Medicaid HMOs Under Scrutiny,* Health News Florida (July 21, 2010), available at http://hnfarchives.org/hnf_stories/read/medicaid_hmos_under_scrutiny.

[14] Press Release, Office of Florida Attorney General Pam Bondi, "Florida Recovers More Than $54 Million From WellCare in Medicaid Fraud Settlement," (Apr. 4, 2012), available at www.myfloridalegal.com; Carol Gentry, *Wellcare Whistleblower Stands in the Way of Settlement,* FLORIDA HEALTH NEWS TODAY (May 3, 2011), available at http://health.wusf.usf.edu/post/wellcare-whistleblower-stands-way-settlement.

[15] John Dorschner, *Study Knocks Bush Dental Plan,* MIAMI HERALD (July 30, 2006) (enclosed). *See also* Elizabeth Shenkman, Institute for Child Health Policy University of Florida, *Evaluation of the Miami-Dade Prepaid Dental Health Plan Year 1 Baseline Report* (June 27, 2006).

[16] Mike DeBonis, *Chartered Could Owe D.C. Health Providers $85 Million,* WASHINGTON POST (April 19, 2013); Press Release, Government of the District of Columbia (June 27, 2013).

[17] Beth Musgrave, *Judge Rules Kentucky Spirit Can't Pull Out of Medicaid Contract A Year Early,* BLUEGRASS POLITICS (May 31, 2013), available at http://bluegrasspolitics.bloginky.com/2013/05/31/judge-rules-kentucky-spirit-cant-pull-out-

of-medicaid-contract-a-year-early/; Open Minds, *Kentucky Court Rules Centene's Subsidiary Cannot Terminate Medicaid Managed Care Contract Early Without Fines, Centene Appeals* (June 24, 2013).

[18] Kaiser Health News, *Tennessee Officials Shift 279,000 TennCare Enrollees to New Plan after AccessMedPlus' 'Premature Collapse,'* (Oct. 22, 2001), available at http://www.kaiserhealthnews.org/Daily-Reports/2001/October/22/dr00007587.aspx?p=1.

[19] Kaiser Commission on Medicaid and the Uninsured, *Transitioning Beneficiaries,* supra n. 1.

[20] *K.C. ex rel. Africa v. Shipman,* 716 F.3d 107, 112 (4th Cir. 2013).

[21] *Salazar v. D.C.,* 596 F. Supp. 2d 67, 69-70 (D.D.C. 2009).

[22] *J.K. by and through R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993).

oklahoma complete health

August 21, 2020

Kevin Corbett, CEO
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
405-522-7300
procurement@okhca.org

Re: Response to Request for Public Feedback #80720200002

Dear Mr. Corbett,

Oklahoma Complete Health, Inc. is pleased to have the opportunity to respond to the request for information from the Oklahoma Health Care Authority regarding the Comprehensive Managed Care Program.

Oklahoma Complete Health, a wholly owned subsidiary of Centene Corporation (Centene), was established to deliver quality, accessible Medicaid managed care services for Oklahomans.

Backed by the nation's largest Medicaid Managed Care Organization (MCO), Oklahoma Complete Health benefits from over 35 years of experience of its parent company and affiliate companies. Our affiliates serve 12.5 million individuals in 29 states through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), Modified Adjusted Gross Income (MAGI), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), foster care, Medicaid Expansion Populations, Long Term Services and Supports (LTSS), and Medicare-Medicaid Plans (MMPs). This breadth of services has driven Centene's expertise in managing member care across products and payors since 1984.

Oklahoma Complete Health supports whole-person care that is person-centered, community-anchored, culturally responsive, and self-determined through integrated systems, training and education, and data sharing and transparency. Our framework is based on the core belief that health care is best delivered locally, and provided in partnership with community, regional and statewide agencies. This belief is the essence of who we are, what we do, and how we serve our members every day. We support providing care that improves member outcomes while

reducing administrative burden for providers and increasing program efficiency and transparency with our state partners.

We hope our responses provide you with information you find useful in planning the SoonerCare Comprehensive Managed Care program design, upcoming request for proposals (RFP), and evaluation criteria to assess MCO capabilities as requested in the upcoming RFP. We look forward to your review, and to answering any additional questions you may have. Please feel free to contact me by the information listed below.

Sincerely,

Zane Yates
Sr. Vice President, Business Development
Oklahoma Complete Health
Centene Corporation
7700 Forsyth Blvd
St. Louis, MO 63105
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Response to the SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

RFI #80720200002 | Due Date: August 21, 2020





oklahoma complete health™

Managed Care Enrollees

1. How and when should OHCA transition ABD and other initially excluded individuals to managed care?

Oklahoma Complete Health's parent company, Centene Corporation (Centene), is an industry leader in managing care for complex Medicaid populations including Aged, Blind and Disabled (ABD) (dually eligible and non-dual). Centene is a national leader in Managed Long Term Services and Supports (MLTSS), operating the largest MLTSS program in the United States by membership. Our current membership across the country reflects our experience and readiness to provide services upon commencement of the Comprehensive Managed Care Program:

- Medicaid managed care services for over 1 million ABD members across 23 states
- Medicare-Medicaid Plans (MMPs) in 6 states with 60,000 members
- MLTSS in 14 states serving over 360,000 members

Centene has over 35 years' of Medicaid managed care experience spanning 29 states, and over the last decade, we have welcomed 11 million new Medicaid beneficiaries including Temporary Assistance for Needy Families (TANF), Long Term Services and Supports (LTSS), ABD, foster care, and Children's Health Insurance Program (CHIP) through our successful implementations of 13 new Medicaid managed care plans. Our experience includes supporting our state partners in eight transitions from fee-for-service models to Medicaid managed care.

- Six of our new health plan implementations have included ABD members; those health plans included over 542,200 members at go-live

Centene health plans have partnered with states to transition complex populations into a managed care program either upon initial implementation of managed care, or through a phased-in approach. Regardless of how the OHCA decides to move these populations into the Comprehensive Managed Care Program, Oklahoma Complete Health suggests including consumers dually eligible for Medicaid and Medicare, and those currently eligible for waiver services. We also strongly recommend a thoughtful and inclusive communication strategy with stakeholders including beneficiaries, caregivers, advocates, as well as organizations such as the Centers for Independent Living, Area Agencies on Aging, and the Nursing Facility and Hospital Associations.

Should the OHCA decide to transition ABD and other initially excluded populations at a later date, based on Centene experience and Oklahoma Complete Health's preliminary work within

the State, we recommend that transition take place within two years of the initial contract start date. This will allow for the greatest opportunity to improve health outcomes and quality of life, and achieve cost savings and budget predictability for the State.

Assessing Experience

We recommend the RFP include questions that assess the bidder's experience managing complex populations, including providing LTSS, in Medicaid markets. The OHCA should weight the assessment of that experience to credit MCOs able to demonstrate successful management of complex Medicaid populations.

2. Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

Oklahoma Complete Health's affiliates have experience providing Medicaid managed care services for all populations, and we are ready to support total population health in Oklahoma. Our parent company Centene has over 35 years' of Medicaid managed care experience, providing Medicaid and Medicaid-related health plan coverage to 12.5 million individuals in 29 states. Our focus and expertise is in serving members through government-subsidized programs, including TANF, Modified Adjusted Gross Income (MAGI), the CHIP, Supplemental Security Income (SSI)/ABD (collectively ABD), foster care, Medicaid Expansion Populations, LTSS, and MMPs.

Oklahoma Complete Health recommends that the OHCA consider requiring MCOs to have significant experience managing all Medicaid populations, including those specialty populations included in this question.

We do not recommend separate specialty plans for American Indians/Alaska Natives (AI/AN), Individuals with Serious Mental Illness (SMI) or other population subsets. However, we strongly recommend that the OHCA consider a single, statewide specialty plan for children in foster care, including those adopted from and who age out of foster care. Our affiliates' experience as a sole source foster care specialty plans has demonstrated that when there is one MCO managing this population throughout the State, there an increased opportunity for transformative care that is responsive to the unique needs of these children. In addition, with only one

Affiliate Experience

5 sole-source contracts in FL, IL, KY, TX, and WA

2 preferred managed care entity states in LA and MS

13 more multi-source foster care contracts in AZ, CA, IA, IN, KS, MI, MO, NE, NH, NJ, NM, OH, and OR

MCO, there is less fragmentation in care, less administrative burden for key stakeholders and providers, and better communication across the system.

Providing Care for Eligible Children and Youth

Oklahoma Complete Health, through our parent, Centene, has unparalleled experience administering contracts for children and youth in foster care as well as children and youth adopted from foster care. Our affiliated health plans manage services for 180,000 youth in foster care in 20 states. In addition, Centene was the first managed care organization in the nation to hire 1 of only 50 Trauma-Focused Cognitive Behavioral Therapy model experts in the country as a full-time, dedicated Director of Trauma and Evidence-Based Intervention.

3. How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Improving Health Engagement and Healthy Behaviors

Engaging Medicaid members in healthy behaviors requires a different lens and emphasis when compared to commercially insured or Medicare populations. They often experience a higher prevalence of multiple chronic and non-chronic conditions, making engagement and the activation of healthy behaviors more critical to wellness. Medicaid members also often encounter distinctive barriers, including health disparities and low health literacy, which impact their ability to engage in their health care. Oklahoma Complete Health, part of Centene, the nation's largest Medicaid managed care company, welcomes the opportunity to support Oklahoma Medicaid members through our comprehensive population health framework.

Key Components to Successful Member Engagement

We recommend that a Medicaid member engagement program begin with stakeholder collaboration to develop, design, review, and deploy engagement programs aimed at improving health outcomes. Engagement activities should support, not supplant, existing successful efforts by local organizations, health departments, and faith-based groups. MCOs should align efforts with the OHCA Strategic Plan and other documents addressing the health of Oklahomans, such as the Oklahoma Health Improvement Plan.

Engaging Medicaid members requires a personal touch. For example, MCOs should be prepared to work with local health influencers in each community to identify the needs of Medicaid members in that community. MCOs can then tailor their member engagement strategies to address specific regional and cultural norms for maximum impact. Successful MCOs should employ an extensive array of "boots on the ground" staff hired from the local community and trained for member and community engagement. We also recommend the OHCA encourage

MCOs to use member and stakeholder advisory councils to discuss engagement opportunities, create improvement initiatives, and review and share results.

MCOs should design targeted outreach based on member needs, interests, and circumstances, and deliver it using an individual's preferred method of communication. Oklahoma Complete Health understands the type and frequency of contact that are most likely to engage a particular member. MCOs also should demonstrate an ability to determine individual and community-level health information needs through sophisticated analyses. To maximize impact, we recommend that MCOs offer tested, successful processes for obtaining and maintaining accurate member contact data.

Monitor and Report Progress for Transparency and Improvement

To maintain transparency and good stewardship of public funds, we recommend that MCOs monitor and report engagement outcomes metrics. Each MCO uses HEDIS results as a baseline measurement and for year-to-year analyses of health improvement goals. MCOs also measure and monitor quality improvement activities, provider engagement with members, provider quality scores, member satisfaction, and results of engagement programs across a wide range of metrics. MCOs use the results of these monitoring/measurement activities to refine and improve their member engagement strategies. MCOs also should share best engagement practices and lessons learned with State and community stakeholders.

Benefits Provided through MCOs

4. What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Facilitating Access to Care

A comprehensive and diverse provider network, built on relationships with safety net providers such as Federally Qualified Health Centers (FQHC), Rural Health Centers, Community Mental Health Centers (CMHC), and tribal providers makes it easier for members to access services. From there, MCOs should partner with local associations, networks, and providers to better understand local needs and expand access to a wide range of services.

Telehealth services allow providers to improve the availability of specialty care in rural areas. Considering Oklahoma's vast rural areas, we recommend that the OHCA permanently allow telehealth use through secure telehealth solutions and over the telephone, as appropriate, when members lack access to telehealth equipment. In addition to improving the availability of care in rural areas, telehealth has enabled providers to facilitate safe access to many services during the COVID-19 pandemic and similar public health emergencies.

By implementing patient-centered Primary Care Care Management models and connecting members to patient-centered medical homes in many states, we know these models facilitate access to integrated physical and behavioral health (BH) services. These models also support the coordination of comprehensive wraparound services that address social determinants of health (SDOH).

Finally, research shows that Community Health Workers (CHWs) have demonstrated success in improving access to—and the use of—services and screenings, health literacy, adoption of healthy behaviors, and adherence to health recommendations. We recommend the OHCA allow MCOS to utilize CHWs as care extenders in the community For example, CHWs can support access to primary care providers (PCPs) by ensuring members get to appointments or coordinating care in tandem with PCPs.

Mitigating Barriers to Care

MCOs provide a powerful technology infrastructure to monitor all elements of a member's care through data platforms and analytics at the individual, community, and population levels. As a result, we can tailor programs to meet individual member needs in real time and evaluate interventions for efficacy and value to help them resolve problems accessing care. With predictive modeling, MCOs should target interventions to steer members to appropriate levels

of care and help them and their communities stay healthier. In addition, MCOs should offer a range of tools (e.g. mobile apps, texting campaigns, social media, member and provider portals, etc.) to support patient-provider-MCO communication.

Local organizations, members, and community leaders are experts in understanding the needs, strengths, and barriers to health in their communities. MCOs can monitor best practices nationally—and partner locally—to customize programs that improve access to services and targeted health outcomes for Medicaid populations and individuals. MCOs also can leverage support resources from national partnerships.

5. What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Strategies to Promote the Integration of Services

Carve In Appropriate Services

We agree with the OHCA's strategy to carve in appropriate services into the SoonerCare program. In our experience, we have found that state Medicaid agencies who carve-in services such as BH (both mental health and substance use disorder [SUD] services), vision, pharmacy, and dental can more easily facilitate service integration, care coordination, and data sharing to the benefit of both providers and members, who are able to navigate the system more seamlessly. In addition, integration will help the OHCA achieve administrative efficiencies, reduce provider burden, and allow for value-based payment (VBP) strategies with the ultimate goal of improving health outcomes for Oklahomans.

Create Avenues for Effective Communication

To foster an environment of joint ownership between physical and BH, providers need to understand the unique differences that each provider brings to the team and be willing and able to communicate effectively with one another. MCOs can help facilitate and coordinate conversations between providers and should look for opportunities to improve communication and education whether it be through technology or by supporting the formation of collaborative care teams. Increasing communication and understanding promotes better partnerships; reduces unnecessary, counter-productive, and inefficient over-utilization of inpatient services; and results in anticipated improved outcomes for members.

Provide Opportunities for Incentives

MCOs can achieve service integration in a number of ways including through incentives for referrals and care coordination between physical and BH providers. The OHCA should

encourage MCOs to offer innovative methods for incentivizing and measuring physical and BH coordination.

Explore Integrated Models of Care

Across the managed Medicaid industry, MCOs and their State partners have designed several models to improve the integration of services. Integrated models include co-located and virtual care that allow for physical and BH integration within the same office, reducing barriers associated with geographic distance, and further enabling care coordination and administrative simplicity. Other integrated models include the Collaborative Care and patient- centered medical home (PCMH) Models, and we support the OHCA in building upon the PCMH strategy.

Invest in Technology to Support Enhanced Care Management

The OHCA, MCOs and providers can use information technology in a variety of ways to enhance care management. The OHCA should encourage MCOs to support interoperability standards as published by the State and by the US Department of Health & Human Services Office of the National Coordinator for Health Information Technology (ONC). Additionally, the OHCA may want to leverage a tool like the Integrated Practice Assessment Tool (IPAT), published by the Health Resources and Services Administration (HRSA), to measure how well providers integrate physical and BH services. With a deeper understanding of a providers' technology capabilities, MCOs are better able to support adoption and integration of platforms for care management, virtual visits, referral tracking, collaboration, and data sharing.

Leverage Technology for Provider Education. MCOs should establish a "no wrong door" approach to provider education, enabling training and support through multiple venues. Providers should be able to access a variety of educational materials, including procedural best practices for integration and avenues for continuing education, among other topics. Providers need flexibility to access education in a way that best suits their needs whether it be through in-person training, webinars, the provider portals, or public websites.

Leverage Technology for Shared Assessments. MCOs can use technology to house universal tools and assessments. The OHCA may want to work with MCOs to define universal assessments and screening tools to be implemented at various levels of care. This helps provide a consistent experience for members and reduces the burden on BH providers working to accommodate disparate MCO practices.

Leverage Technology for Secure Data Sharing. Secure data sharing through role-based technology is the backbone to integrating services. The OHCA should encourage providers and MCOs to connect to a State-supported Health Information Exchange (HIE) to enable hospital

event notification (e.g. Admission, Discharge and Transfer [ADT]) sharing. Through referrals and more timely data, care teams can act promptly to improve member care. MCOs should leverage technology that can integrate various forms of data, (e.g. physical and BH claims, pharmacy claims, lab data, assessments, social determinants, etc.) to provide care teams with a unified source from which to work. Additionally, there are benefits to adopting technology that can integrate with state registries like the Prescription Monitoring Program (PMP) or the Oklahoma State Immunization Information System (OSIIS).

6. How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

Addressing Social Determinants of Health

Oklahoma Complete Health understands how deeply SDOH impact Medicaid-eligible individuals and families, and we are committed to identifying and mitigating SDOH barriers to improve health outcomes and reduce costs. Centene along with our affiliated health plans has helped strengthen communities and address SDOH since 1984. Based on this experience, we support consistent health screening and assessment, stakeholder partnership, and supportive technology, and resources.

Screenings and Assessments

Effective screenings and assessments are essential to identify members in need of social services and to collect SDOH data to develop and improve referrals, intervention, and evaluation. We support SDOH screenings when a beneficiary applies for Medicaid, and at every appropriate opportunity thereafter, as needs often change on a regular basis. Ideally, assessment, re-assessment, and reconciliation of social service needs is the responsibility of an interdisciplinary care team (e.g., PCPs, MCOs, community-based organizations [CBOs], care managers, BH providers, etc.). We also recommend the use of evidence-based assessment tools that include nationally validated questions to identify social needs, and we encourage local stakeholders to use their preferred tools. Evidence-based assessments support data collection needed to improve all aspects of health and well-being. We also support the OHCA's 2018-2022 Strategic Plan proposal to expand the use of motivational interviewing.

Community Partnerships

Collaborative partnerships are the cornerstone of addressing SDOH, including facilitating and tracking referrals and evaluating outcomes. Local stakeholders best understand the availability and quality of social services in their communities. As such, they should be involved in developing referral and tracking strategies (e.g., identifying and addressing service

gaps and supporting CBO staff, etc.). MCOs should partner with stakeholders (e.g. providers, CBOs, schools, etc.) using community engagement best practices to make sure these stakeholders have a voice and clear roles and responsibilities in:

- Helping members
- Expanding/maximizing use of available services
- Supporting cross-communication, coordination, and evaluation of initiatives.

MCOs can better promote the tracking and gathering of SDOH data when they have the flexibility to develop innovative partnerships.

Supportive Resources

Oklahoma Complete Health has found that tools such as resource and referral platforms allow members to receive the full range of required services. In addition, MCO care management teams should coordinate with community stakeholders to identify and address referral/follow-up issues. CHWs are particularly qualified to help link members to services, and we support State efforts to expand their use in SoonerCare.

Measuring and Evaluating MCO Performance

Oklahoma Complete Health shares the OHCA's overarching goals of improved health and well-being for SoonerCare members, and achieving cost-savings. Ultimately, every effort should lead to those goals. As such, MCOs should focus on implementing processes to consistently identify individuals' social needs, refer them to quality services, and track outcomes to meet these goals. Ideally, the OHCA would work with MCOs to establish realistic metrics to support consistency in screening processes and collecting SDOH data. For example, the OHCA might set preliminary goals for the percentage of members screened/assessed, timeliness of referrals and follow-ups, etc. Starting with a few well-defined measures simplifies data collection and establishes a solid measurement foundation to build upon when MCOs link performance to improved health outcomes and reduced costs.

7. How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

Improving Access to Evidence-Based Behavioral Health Care

Oklahoma Complete Health understands that improving access to evidence-based BH care requires a multi-faceted approach. We recommend the OHCA allow MCOs the discretion to design and implement strategies that improve access to evidence-based BH care. This will allow MCOs the flexibility to develop approaches that encourage innovation, support providers, and

promote adoption. Strategies such as specialized training programs, shared learning opportunities, enhanced virtual BH services, and provider incentives are all effective tools for MCOs to use to increase access to evidence-based BH care.

Additionally, we recommend that the OHCA encourage MCOs to collaborate with CMHCs, providers, other MCOs, community stakeholders, and the OHCA to identify community needs and expand access to services like Assertive Community Treatment (ACT), SBIRT and medication-assisted treatment (MAT) in a way that is tailored to Oklahoma communities and the local health care delivery system. With the OHCA's support, MCOs and providers can adapt approaches for ACT or other evidence-based BH approaches to rural environments or for specific populations and communities in a way that is both efficacious and implementable for providers.

8. What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

Impactful Value-Added Services

Oklahoma Complete Health recommends MCOs have the flexibility to offer a variety of value-added services and cost-effective alternative services and supports (e.g. case-by-case or in lieu of services) not otherwise offered in the Oklahoma Medicaid State Plan. Value-added services tailored to meet the unique needs of each population contribute to increased preventive care activities, improve health outcomes, and member engagement. Allowing MCOs flexibility in determining value-added services allows the OHCA to take advantage of innovative and timely person-centered strategies developed by MCOs while minimizing the effects of economic cycles.

MCOs should offer innovative value-added services that align incentives with the OHCA's priorities and health concerns throughout Oklahoma. For example, value-added services can effectively reduce Emergency Department (ED) utilization, encourage appropriate service utilization, incentivize healthy behaviors, and remove barriers by addressing social determinants such as through programs that provide job readiness, job fairs, and access to educational resources.

In addition to traditional value-added services, Oklahoma Complete Health recommends the OHCA consider encouraging case-by-case or in lieu of services to allow flexibility based on individual member needs.

9. How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Improving Access to Transportation

Oklahoma Complete Health recommends MCOs be committed to getting members to the right place in a manner that is convenient and promotes a positive experience. To improve access to transportation, we recommend that the OHCA and MCOs work with non-emergency medical transportation (NEMT) providers to explore the use of technology for route development, scheduling, and ride reminders. We recommend the OHCA consider increased flexibility in the benefit design to allow for same-day and/or multi-stop transportation as well as cost-effective, more convenient options.

Improving Member Access to Transportation

To improve member access to transportation, we recommend that the OHCA encourage local NEMT providers to offer flexibility in the provision of services. MCOs should collaborate with NEMT providers to enhance coordination and improve service delivery.

Ride-Sharing Services

We recommend the flexibility to continue reimbursing ride-sharing options for members. Based on our affiliate experience, ride-sharing services are an effective transportation for Medicaid programs and an opportunity to increase access to NEMT in rural areas. Affiliate data shows that using ride-sharing for NEMT services significantly decreased rider complaints, substantially reduced wait times for riders compared to traditional NEMT transportation options, helped reduce costs, improved overall customer experience, and decreased the number of logistical issues that make traditional NEMT options costly and inefficient.

When addressing the specific transportation issues experienced by Oklahoma Medicaid, MCOs and stakeholders should collaborate to identify and address local issues. Together, the group should consider the types of transportation needed, the model of service delivery, and the policies that govern transportation. This will help identify opportunities to streamline processes, remove barriers to care associated with transportation, reduce administrative burden, and contain costs.

Quality and Accountability

10. What mechanisms should the state use to incentivize MCOs to improve member outcomes?

Improving member outcomes is a fundamental goal for all MCOs, particularly those that serve Medicaid members. Oklahoma Complete Health recommends the OHCA prioritize member outcomes that are most critical for individuals served by the SoonerCare program and establish clear goals and objectives that align with those priorities. We recommend the OHCA link incentives to these goals and objectives, and use standardized, validated metrics to measure MCO performance. Additionally, we recommend the OHCA employ measurement and improvement approaches that allow MCOs to establish baseline data, implement improvement activities and follow continuous quality improvement methodology.

Developing MCO Incentive Programs

In the past decade, our affiliate health plans, guided and supported by our parent company Centene, partnered with eight states as they transitioned from a fee-for-service (FFS) to Medicaid managed care model. Through that experience, we have identified key considerations in developing MCO incentive programs that evolve over time since improvement in member outcomes is a gradual process. These considerations include:

- **Contract Year One.** During the first year of the contract, we recommend focusing on the fundamentals of operations such as credentialing providers, timely claims payment, and prior authorization (PA) turnaround time. The first year should allow for valid baseline data to be gathered as the MCO engages members in appropriate levels of service through activities such as connecting members to a medical home, assessing current health and wellbeing including SDOH related needs, addressing immediate needs, and focusing on preventive care.
- **Contract Year Two.** Starting in year two of the Contract, we recommend pay-for-performance (P4P) incentives tied to NCQA HEDIS measures as further detailed in our response to Question 12.
- **Subsequent Contract Years.** During subsequent contract years, the incentive program can continue to refine these metrics, and expand to additional metrics as MCOs achieve their goals and move toward a risk-based framework.

11. What are the most important indicators of MCO performance? Why?

Commonly Used Performance Indicators

There are two types of performance indicators commonly used to measure MCO performance and drive sustained improvement. Oklahoma Complete Health recommends the OHCA use one

of these two types of performance indicators, which are the most common in State Medicaid Agency performance programs:

- **Performance to Threshold.** This indicator is based on an MCO achieving a level of performance established by the State; thresholds could be based on national averages or on performance data the State has collected.
- **Percentage of Improvement.** This indicator focuses on an MCO's continuous improvement in key metrics over time.

Both approaches allow the OHCA to view any metric critical to SoonerCare populations, using a valid and standardized approach for all MCOs. As referenced in our response to Question 10, we encourage the OHCA to implement a defined set of metrics that align with its priorities, and allow time for baseline measurement, implementation of initiatives, and re-measurement periods to allow for meaningful performance improvement.

12. What measures of health outcomes should be tracked?

Identifying and Tracking Outcome Measures

Oklahoma Complete Health recommends that the OHCA collaborate with MCOs and providers to identify outcome measures that strategically align with key priorities and the OHCA quality goals. Aligning quality measures with State priorities helps drive system-wide improvements in health outcomes and quality of care. Additionally, we recommend that the OHCA consider limiting the volume of process and outcome measures to a manageable number of well-defined, nationally recognized measures. Limiting the number of measures emphasizes key the OHCA priorities and goals. Starting with a few well-defined and realistic measures will help establish a solid measurement foundation and simplify data collection.

We also recommend a phased approach, initially focusing on process measures as there is a transition period during which MCOs assess new member health and wellness needs, and engage them in process related activities such as well-visits, and preventive care. These measures should balance the need for the OHCA to assess provider and MCO performance against the administrative burden and cost implications to the State, providers, and MCOs.

When identifying and prioritizing potential outcome metrics, Oklahoma Complete Health recommends that the OHCA consider domains of care (i.e. access and availability, utilization, effectiveness of care) and measure indicators within those domains to assess MCO performance.

Care Management and Coordination

13. How can utilization management tools work best for members and providers?

How Utilization Management (UM) Tools Work Best for Members and Providers

Oklahoma Complete Health supports the use of UM tools that emphasize clinically appropriate care, streamlined access to services, timely notification and reduced provider administrative burden. Generally, MCOs use the UM approaches described below to support UM practices that ensure members receive the right care at the right time and in the right setting. UM tools can work best for members and providers by:

Being Easy to Understand

MCOs have an opportunity to confirm that members and providers have a clear understanding of the available benefits prior to requesting authorization for services. Tools such as comprehensive provider directories and member websites offer visibility into participating providers and benefits, which leads to informed care choices. Delivering clear information about covered services can lead to appropriate utilization and access to quality care, eliminate balance billing, and result in fewer Single Case Agreements. MCOs should also distribute a detailed Explanation of Benefits notifications for services provided. Additionally, MCOs should notify members and providers of authorization approvals, denials and/or adverse determinations in UM Decision and Notification Letters. MCOs should make sure these notifications thoroughly explain the rationale used to make the UM decision and write them in an easily understood manner.

Providing Support and Education

Tools such as MCO nurse advice lines can provide clinical education and support related to accessing the right level of care. A nurse advice line triages a member's medical concerns and directs them to an appropriate level of care – whether that is self-care at home, a visit to the member's PCP or a visit to Urgent Care or ED. Additionally, nurse advice line staff are available to educate members about covered services and other program components including, but not limited to, referrals and authorization processes.

To support providers, MCOs should provide a dedicated provider service line that offers an efficient, one-stop service for assistance and information, which enables providers to devote more time to serving members. For example, providers can call this line to receive an update on the status of a pending authorization and be connected to a UM nurse for more timely decision-making. MCOs can also offer providers educational UM tools that describe the types of

services that require authorization, medical necessity criteria and guidelines, forms and processes, and determination timeframes.

14. How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

Encouraging Consistency Across MCOs

Oklahoma Complete Health supports a focus on reducing administrative burden so providers can focus on what they do best – delivering quality care to members. Using evidence-based criteria guidelines, standardized forms and processes, and digital technology solutions could simplify authorization approval processes and encourage consistency across MCOs.

Promoting Use of Evidence-based Criteria Guidelines

The OHCA can encourage MCOs to use industry standard clinical criteria, such as InterQual Criteria and Association for Addiction Medicine (ASAM) guidelines to promote UM consistency across MCOs and standardize clinical determinations made by UM staff. The application of clinical criteria like InterQual and ASAM criteria by all MCO UM staff can also support cost efficiency while ensuring members maintain access to high quality health care services.

Standardized Prior Authorization Forms and Processes

We recommend the OHCA collaborate with MCOs and providers on the development of unified prior authorization forms or processes for use by all MCOs. This would eliminate the need for provider training on multiple MCO policies and procedures. In collaboration with the OHCA and other MCOs, we also support potential future innovation for processes that continue to work towards streamlining the prior authorization process to reduce provider burden.

Standardized Provider Appeal

The OHCA should consider establishing a streamlined, standardized process for provider appeals to reduce provider administrative burden. The OHCA can collaborate with MCOs in development of a process that, at minimum, meets NCQA requirements.

Digital Technology

Provider satisfaction and member health outcomes improve when providers can focus on serving members instead of completing paperwork. The OHCA should require MCOs to employ web-based resources and automated platforms that offer provider self-service options, which can lead to a simplified UM process. We recommend the OHCA consider digital UM tools that reduce unnecessary paperwork and support providers throughout the UM process.

Reducing Provider Burden

MCOs can offer self-service options that simplify UM processes and create a seamless provider experience. These technologically innovative, digital UM tools allow MCOs to deploy a data driven approach to reduce unnecessary paperwork and support providers throughout the UM process. Technology-based solutions related to provider notification tools can improve health outcomes, support timely authorization of services, and help providers identify members with co-occurring health conditions who are at increased risk of readmission. MCOs can offer providers self-service options that simplify UM processes and ensure a seamless experience for providers.

15. What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

Approaches to Better Meet Member BH Needs

Oklahoma Complete Health recommends the OHCA, MCOs, providers, and stakeholders routinely collaborate to review care delivery strategies and/or BH programming to determine which approaches best address the needs of Oklahoma's communities. Collaboration between the OHCA, MCOs, and providers would also promote identifying and addressing potential care coordination challenges or concerns, such as where to refer an individual who may benefit from specific types of BH care and inform future strategies to improve and streamline BH care delivery. Oklahoma Complete Health suggests the following MCO network development, care delivery, and care coordination approaches to improve care and better meet a member's BH needs:

Network Development

- Offer virtual access to BH providers as an alternative to in-person care
- Encourage adoption of VBP models
- Support local BH priorities that promote integration

Care Delivery

- Encourage PCPs to administer BH screenings
- Use and promote evidence-based practices
- Incorporate BH screening questions in MCO Health Risk Screenings
- Identify and stratify members with BH co-occurring conditions early
- Screen for SDOH barriers

Care Coordination

- Hire local, dedicated staff resources for BH care management services

- Provide coordination of services and referral linkage, as needed
- Offer support for members during BH crisis events
- Promote and facilitate data sharing

16. How can MCOs improve the management and coordination for members with chronic or complex health conditions?

Improving Management and Coordination

MCOs can improve the management and coordination for members with chronic or complex health conditions by creating a system of care around the member that includes their family of choice, caregivers, providers, and social/community supports. MCOs can also empower the member to be an active participant in their care through integrated care management services and condition-specific programs and tools that enable them to be as self-sufficient as possible. MCOs should also partner with the OHCA to promote system-wide adoption of a person-centered approach by sharing best practices and acting as champions for person-centered practices within their organization and across the SoonerCare Program.

The following are some of the components of a comprehensive strategy for improving MCO management and coordination for members with chronic or complex health conditions:

- Integrated benefit packages with behavioral/physical health, pharmacy, dental and social supports managed by the MCOs.
- Intimate understanding of the population, including disease states and health disparities. MCOs should hire local staff with diverse clinical backgrounds who bring clinical expertise for the most prevalent conditions and train others on managing chronic, complex conditions.
- Fully integrated, interdisciplinary care models (MCO or provider-based) that address all of a member's complex needs, including medical, BH, pharmacy, dental and social.
- Quality-based payment systems to reward providers for improving health outcomes. MCOs should engage providers in value-based purchasing models that incentivize, for example, integration of BH and social determinants with physical health, enhanced care coordination, and measurable improvements in health outcomes.
- Technology supports for data sharing amongst all care team members, access to ADT and Electronic Medical Record (EMR) data to identify hospital admits/discharges, and access to care information via a provider portal.

- Partnerships with CBOs that can address SDOH barriers such as education, living situation ((e.g. urban/rural; home safety issues, etc.), food insecurity, or employment; and identified health disparities.
- Caregiver supports to provide support and relief, such as with respite or meal preparation.
- Access to providers, specialists, and/or programs remotely via telehealth, particularly in rural areas. This access is also essential for the safety of individuals with complex conditions during COVID-19, which enables them to avoid exposure risks at a provider office or hospital facility.
- Different modalities MCOs can leverage to address members' chronic conditions, including digital tools and remote monitoring, as well as in-person and virtual visits.

Chronic Condition Management and Member Engagement

MCOs should build upon the framework of the OHCA's care coordination model offered as part of SoonerCare Choice by offering evidence-based chronic condition care management programs, coaching and support for prevalent conditions and health issues within the Oklahoma SoonerCare population, such as asthma, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, heart failure, and hypertension. MCOs should design these programs with a holistic approach to member health, while considering unique needs presented by specific conditions and health disparities. MCOs can also conduct targeted outreach and health education in priority areas and on emerging issues.

Based on our affiliates' experience helping members manage chronic conditions, Oklahoma Complete Health also knows that MCOs must tailor outreach and support to the member's risk level for the best result.

17. What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Reducing Barriers to Care

Generally, MCOs offer the following services and approaches to reduce barriers to care and improve coordination for members whose needs present unique considerations.

- **A System of Care Approach** that is person-centered and rooted in trauma-informed care. Care coordination is collaborative, flexible, and tailored to the unique needs of each member

- **A Referral Entry Point Workflow** to support streamlined referral and coordination processes for members
- **A Designated Care Manager** or other dedicated staff, such as a liaison, to act as a member's primary point of contact or to work in conjunction with the designated care manager on behalf of the member
- **Collaborative Care Planning** with a member and their family and/or support system to promote smooth care coordination processes.
- **A Comprehensive Training Plan** to support MCO staff, providers, and other stakeholders in caring for members with unique considerations
- **Data Sharing** between MCOs and other stakeholders to identify barriers to care, improve coordination, and promote integration to better serve members.

Below, Oklahoma Complete Health describes additional methods MCOs should consider to reduce barriers and support streamlining care coordination for populations whose needs require unique considerations.

Children in Foster Care

Children and youth in foster care are a small, but unique Medicaid population: they may have experienced trauma, are transient, and often require extensive services and supports to wrap around the member and their guardians. Given the size and transiency, it is our experience that a single, sole source MCO for the foster care population reduces barriers and fragmentation, improves care coordination and outcomes for members. Based on our experience serving children in foster care as previously described, we recommend a single, statewide MCO contract to serve children in foster or who are receiving assistance with adoption. This approach will reduce barriers to care and fragmented services, while improving care coordination. In a sole source environment, an MCO also can collaborate closely with key stakeholders, such as the OHCA, CBOs, and providers to enhance communication across the system.

American Indian/Alaska Native (AI/AN) Members

Based on our experience collaborating with Tribal Governments, we recommend MCOs include tribal-centric positions in their staffing plans. These positions can act as the primary liaison or coordinator with Tribal Nations, Tribal Leaders, Indian Health Care Providers, community organizations, and the MCO for the overall delivery of health services for AI/AN members. The position(s) can support AI/AN program development, facilitate staff training to promote cultural

awareness, collaborate with MCO staff, and facilitate system improvement to reduce barriers such as transportation concerns, access to care, and education about benefits.

Individuals with Serious Mental Illness (SMI)

The life expectancy for individuals with SMI averages 9 to 32 years less than individuals without existing health conditions. The premature mortality of individuals with SMI is often due to chronic co-occurring health conditions such as diabetes and schizophrenia. For this reason, MCOs should support evidence-based models such as the Collaborative Care Model, which focuses in integration of BH care in primary care settings.

Individuals with Justice System Involvement

According to the Oklahoma Policy Institute, youth in Oklahoma with justice involvement often have a history of trauma and corresponding positive Adverse Childhood Experiences (ACEs) scores. In fact, nationally, Oklahoma has the highest rate of children with at least one ACE score, which includes having a parent in prison and an abuse history. To support these needs, MCOs should develop specialized programming for individuals with justice system involvement. This includes programming focused on evidence-based approaches that may contribute to lower rates of reoffending. Other strategies include maintaining a network comprised of BH providers who offer comprehensive BH services and care planning, and closely collaborate with CBOs to reduce barriers such as housing, employment, and/or services to support reentry into the community.

Member Services

18. What metrics should be used to measure MCO performance with regards to member services?

Dedicated to Maintaining Member Service Excellence

Oklahoma Complete Health supports the OHCA in their effort to establish develop a service level agreement (SLA) with standard metrics across all MCOs in order to monitor and measure performance of MCO's member services departments. Serving over 12.5 million Medicaid enrollees in 29 Medicaid health plans across the country, Oklahoma Complete Health, backed by our parent company, Centene, has over 35 years of experience partnering with our state clients to track and report member services metrics that meet or exceed state contract requirements. We are guided by best practices and the ultimate goal of first call resolution for members and to ensure members have their questions/needs met. Centene maintains more than 82 contact centers across the United States with over 19,500 customer service representatives (CSRs) collectively taking 38 million calls annually.

Oklahoma Complete Health supports the OHCA in their effort to establish standard metrics across all MCOs for monitoring and measuring the performance of MCO member services functions.

Example MCO Performance Metrics

We recommend that the OHCA provide clear direction to MCOs on the metrics being measured in MCO contracts, account for population-specific differences, develop a standard form for MCO submission of metrics to the OHCA, and provide transparency in member services performance across MCOs.

Based on our experience, we recommend the OHCA consider measuring MCO performance using monthly metrics that align with National Committee Quality Assurance (NCQA). Examples of the common metrics for measuring Medicaid managed care plans member services team performance include:

- Average speed of answer (e.g. 30 seconds standard)
- Call abandonment rates (e.g. 5% of calls)
- Service levels (e.g. 80% of calls answered within 30 seconds)
- Capture rate (calls answered as a percent of total call volume over a period of time)
- Blockage rate
- Call Audits (e.g. 95% score against internal audit tool)

19. How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?

Removing Language Barriers for Non-English Speaking Members

Language should never be a barrier to understanding or accessing health care. MCOs can best serve individuals who primarily speak a non-English language by developing and deploying a multi-modal approach to communicate with members in their preferred language about wellness activities, covered and non-covered benefits, general health care information and clinical services.

Our recommended multi-modal approach accounts for communication delivered by MCOs and their provider networks. MCOs should hire local staff to reflect the cultural, linguistic and health literacy needs of the community. MCOs and their providers should communicate with members in their preferred language and provide written and verbal language services to those who primarily speak a non-English language through modalities such as telephone/remote interpreters, in-person interpreters, written translations and alternate formats. This approach also includes consistent and thoughtful data analytics to better understand trends in member demographics, including preferred language, and shifting modalities to respond to member needs and ensure they receive the highest quality of care.

Serving Members Who May Not Understand Health Care Terminology

Oklahoma Complete Health recognizes that increasing members' knowledge of health care terminology leads to increased engagement and healthier outcomes. A member's ability to, for example, understand the directions on a prescription label, self-manage care for a complex disease or even search for a particular provider requires a level of proficiency in health care terminology. As such, MCOs should offer a comprehensive strategy designed to shift members from being passive recipients of care to informed self-managers of their health care.

MCOs can best serve members who may not understand health care terminology by, for example:

- Developing member facing written materials in an easily readable font using a sixth-grade reading level to maximize comprehension
- Deploying innovative communication methods such as expanding the use of culturally relevant infographics in member materials

- Training member-facing staff, providers and support staff on how best to communicate written and verbal information through strategies such as teach-back, managed care glossaries and 101 training and writing in plain language.

20. How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?

Using Technology to Help Members

MCOs should use technology to deliver a high level of service at every point of member contact to help members understand their health plan benefits, manage their health and wellness, and improve their health outcomes. MCOs typically offer member services call centers, as well as self-services offerings such as an accessible public website and a secure online member portal. MCOs should use these offerings, in concert with innovative digital and telehealth solutions, including mobile health apps, to enable enhanced communication with MCO staff as well as providers.

Member Services Call Center and Nurse Advice Line

A member services call center capabilities with Interactive Voice Response (IVR) integration offers automated support allowing members to answer questions about their health care needs for real-time connections to appropriate care. For after-hours support, MCOs can offer a nurse advice lines for triage, advice, and ED diversion assistance.

MCO Website

MCOs should offer a publicly available website to help members understand their benefits and get the most out of their coverage. MCO websites should also help members understand how to get care, such as choosing their PCP, making an appointment, and getting prescriptions filled. Websites should also include actionable information such as how to access interpreter services and complete a health needs screening.

Secure Member Portal

Member portals offer secure online access to a number of self-service features to support care delivery and care management. These portals should allow a member to view their health information, change their PCP, update their contact information, and complete health risk screenings. Member portals should also offer secure messaging with health plan staff.

Digital Technologies and Telehealth

Digital technology and telehealth can make it easier for members to manage their health and access care when and where they need it. MCOs can offer digital tools, such as health and

wellness mobile applications and telehealth services that help connect members to the right care at the right time.

We applaud Oklahoma's position as an early adopter of telehealth and we encourage the OHCA to continue their policies for reimbursing telehealth services. Further, we suggest that the OHCA consider removing restrictions on eligible patient locations and geography for the SoonerCare program. We also encourage the OHCA to allow MCOs to reimburse and incentivize providers for using telehealth.

Using Technology for Population Health Management

MCOs should identify needs at the population level to inform health messaging and outreach strategies. MCOs should use e-mail, text, voice, and social media services to promote participation in programs, encourage preventive care, and provide health education for individuals, their families, and the community.

21. How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?

Multiple Communications Channels for Member Engagement

Medicaid MCOs should deploy multi-channel solutions for member communications as part of a comprehensive member engagement strategy. Oklahoma Complete Health's affiliates, for example, match the delivery medium (e.g. mail, phone, email) to the member's preference and type of communication (e.g., non-English and alternative formats) to their need. Mobile and internet communications may be part of an MCO's member engagement plan, but they are not the sole option. MCOs often rely on the U.S. Postal Service, for instance, to deliver important and contractually required documents (e.g., ID cards, Notice of Action and member appeal resolution letters, and provider changes). MCOs also use the mail service to deliver information on new programs, member newsletters, and incentives. In addition, MCOs can:

- Routinely review member contact information to obtain both landline and mobile phone numbers for enrolled members. Nationally, about 50% of homes still have landlines.
- Partner with key local influencers and organizations (e.g., faith-based organizations and schools) that already employ effective communications channels to deliver specific wellness and illness prevention messaging campaigns.

Bring Technology to the Member

MCOs can also assist eligible members with navigation assistance to obtain Federal Communications Commission Lifeline mobile phones. Oklahoma Complete Health's affiliates assist members in obtaining mobile phones through the Lifeline program today.

Person-to-Person Communication

MCOs, like Oklahoma Complete Health, often use member-facing staff (e.g. CHWs) for personalized in-community outreach, especially to those identified as at-risk because of chronic, unmanaged conditions, disability, or homelessness. Working directly with members, MCO staff can establish a safe, reliable method of ongoing direct communication. Personal interaction also generates feedback that MCOs can use to develop program and system improvements.

22. How can MCOs communicate with members and receive regular input and feedback on program improvements?

Maintaining Two-Way Communication with Members

MCOs use ongoing two-way communications with members to engage them in healthy behaviors, assist with system navigation, and obtain input to improve programs. For successful engagement, we recommend the OHCA encourage MCOs to:

- Use multiple distribution channels for communications
- Develop and maintain sufficient social media presence and internet platforms to deliver routine and urgent communications
- Provide easy-to-navigate inbound and outbound telephonic communication with technology, processes, and sufficient highly trained and monitored staff to handle all member requests as well as unexpected increases in volume
- Offer in-community staff (e.g., community health workers and advocates) to communicate with members on their individual needs and respond to program requests
- Continuously refresh members' contact information to ensure delivery.

Soliciting Member Feedback

MCOs should use formal and informal approaches to solicit member feedback, and should log input and feedback. For example, all MCOs use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for details on member experiences. MCOs also rely on other member surveys to serve as early warning systems for needed program improvements. These may include surveys after a member call, care management surveys, post-event surveys, and ad hoc surveys, as needed, for drill-downs. Analyses of member call inquiries and real-time monitoring of member grievances and appeals also provide visibility into member satisfaction with programs, access, and services.

MCOs frequently solicit qualitative member input, such as from member advisory committees and focus groups, to drive program improvements. Not all Medicaid members can speak for

themselves, so MCOs should actively seek input from advocacy groups, local influencers, State and local health officials, family members, and caregivers.

23. What tools and resources would help members search for providers? What information should be provided?

Helping Members Search for Providers

MCOs should offer access to a provider directory and encourage members to call the Member Services call center for any assistance needed to find a provider that meets their needs. A searchable online provider directory should be available to members and their parents or caregivers. MCOs should provide easy navigation to the provider directory by linking it prominently on their website, and make printed copies available to members upon request.

The online provider directory should use geo-location services to find providers near a member's location, while also allowing the member to enter their street address, ZIP code, or county. Members should also be able to search by a specific provider name, hospital, or clinic and search by category (e.g., BH, vision). Members should be able to easily search for and find information at both the facility-level (e.g., treatment center) and practitioner-level.

Provider Directory Information

Members should be able to view a practitioner's basic information such as address, gender, credentials, phone number, network status, and group/hospital affiliation. The member should also be able to view the distance of the provider to their location and whether the practitioner accepts new patients. The member should also be able to view practice details such as the location operating hours. MCOs can also include a list of provider-spoken languages, cultural training, or site accommodation for members with disabilities. This helps members search for linguistically and functionally appropriate providers.

Provider Payments and Services

24. What metrics should be used to measure MCO performance with regards to provider services?

Dedicated to Maintaining Provider Service Excellence

Oklahoma Complete Health supports the OHCA in their effort to develop standard metrics across all MCOs in order for monitoring and measuring the performance of an MCO's provider services function. Serving over 12.5 million Medicaid enrollees in 29 Medicaid health plans across the country, Oklahoma Complete Health, backed by our parent company, Centene, has over 35 years of experience partnering with our state clients to track and report member services metrics that meet or exceed state contract requirements. We are guided by best practices and the ultimate goal of first call resolution for providers and to ensure providers have their questions/needs met.

Example MCO Performance Metrics

We recommend that the OHCA provide clear direction to MCOs on the metrics that will be measured in MCO contracts, provide a standard reporting format for MCO submission of performance data to the OHCA, and provide transparency in provider services performance across MCOs. Based on our experience, common metrics for measuring Medicaid MCO provider services team performance include:

- Average speed of answer (e.g. 30 seconds standard)
- Call abandonment rates (e.g. 5% of calls)
- Service levels (e.g. 80% of calls answered within 30 seconds)
- Capture rate (calls answered as a percent of total call volume over a period of time)
- Blockage rate
- Call Audits (e.g. 95% score against internal audit tool).

In addition to the example metrics stated above, the OHCA could also measure MCO provider services performance through monitoring of MCO Credentialing Turnaround Time, and Claims Service (e.g. Claims Payment Procedures and Claims Disputes).

25. Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

Minimum Levels of Reimbursement

Oklahoma Complete Health recommends that the OHCA require MCOs to maintain clearly defined minimum reimbursement levels through a published, actuarially sound, Medicaid fee schedule. We further recommend that the OHCA mandate all MCOs to adhere to, maintain, and

use this Medicaid fee schedule in provider contracting and for ongoing payments to providers. Requiring MCOs to adhere to a published fee schedule facilitates fair and consistent rate negotiation practices and supports the financial viability of traditional Medicaid providers.

Sustaining Provider Compensation

Encouraging and supporting provider success through recognition of superior performance are critical requirements for providing high quality health care and maintaining a comprehensive Medicaid network. Oklahoma Complete Health is committed to encouraging and rewarding high performance and supporting provider progress through a continuum of VBP arrangements. We recommend that the only permissible deviation from an actuarially sound Medicaid fee schedule, developed by the OHCA, be through VBP arrangements and incentives designed to reward performance/outcomes and keep providers financially whole.

Maintaining a minimum level of reimbursement, supplemented by VBP arrangements and incentives that support and award provider success, may also encourage additional Oklahoma health care providers to participate in Medicaid.

26. What is appropriate for timely payment of claims?

Our experience has taught us that it is critical to implement timely claims payment processes at the start of MCO operations. As such, MCOs should offer providers early and ongoing claims training and supports and provide multiple methods for submitting claims and options for receiving payment. To ease administrative burden, providers should have the choice of a claims submission method that works best for them including, but not limited to, submission through the MCO's secure provider portal, multi-payer portal, a claims clearinghouse, batch claim file submissions, through direct data entry, and/or on paper claims.

Industry Standard Payment Standards

Claims processing timelines noted in the table below, are appropriate parameters for efficient payment of claims. MCOs will need to partner with the OHCA to establish appropriate timely claims payment agreements.

Table: Standards for Appropriate Timely Claims Payment Agreements

Standards for Appropriate Timely Claims Payment Agreements
• 90% of clean claims must be adjudicated within thirty (30) calendar days
• 95% of all clean claims must be adjudicated within sixty (60) calendar days
• 99% of all clean claims must be adjudicated within ninety (90) calendar days

27. What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

Oklahoma Complete Health supports the OHCA's efforts to reduce administrative burdens so providers can focus on what they do best – delivering quality care to members. From our affiliated health plans' experience, we understand that standardizing provider services functions and processes can significantly help to reduce these burdens.

Below we provide recommendations for standardizing certain provider services functions across MCOs.

Standardized Credentialing

Oklahoma Complete Health recommends standardizing the provider credentialing process across participating MCOs. This is consistent with the vision of Medicaid transformation and responsive to the concerns that providers have raised regarding increased administrative burdens upon the transition to Medicaid managed care. Our affiliated health plans have experience working with State partners to standardize part or all of the credentialing process. For example, the State of Georgia implemented centralized credentialing in 2015 and the State of Texas implemented a credentialing verification organization (CVO) vendor in 2017.

Should the OHCA consider standardizing the credentialing process, we offer the following recommendations to support a streamlined approach:

- The OHCA should align with NCQA credentialing requirements, including oversight and routine monitoring requirements
- The OHCA should consider a mechanism or process through which MCOs can clarify any questions regarding information received from a NCQA-certified CVO directly with the CVO. We recommend the following to support this streamlined approach:
  - The OHCA should consult with MCOs throughout the implementation process to establish standardized processes aligned with NCQA standards
  - The OHCA should integrate the credentialing process with the provider enrollment process
  - An OHCA-led credentialing committee should align with NCQA standards and include MCO representation
  - MCOs should have access to track status of applications
- MCOs should have the option to delegate credentialing to qualified groups or systems

How this should be accomplished: The OHCA should consider collaborating with MCOs to establish standardized processes and timelines while allowing each MCO to independently manage their provider network.

Barriers to standardizing the function: Oklahoma Complete Health sees no barriers to standardized credentialing with the above recommendations in place.

Standardized Prior Authorization Forms and Processes

We recommend the OHCA collaborate with MCOs and providers on the development of unified prior authorization forms or processes for use by all MCOs. This would eliminate the need for provider training on multiple MCO policies and procedures. In collaboration with the OHCA and other MCOs, we also support potential future innovation for processes that continue to work towards streamlining the prior authorization process to reduce provider burden.

How this should be accomplished: The OHCA should collaborate with MCOs and providers to co-develop and adopt forms and processes.

Barriers to standardizing the function: In an environment with multiple, disparate processes already in place, if the OHCA does not require standardization, impacted groups are most likely to continue their current practices. The OHCA can address this by convening relevant parties and requiring adoption of the agreed standards.

Standardized Provider Appeal

The OHCA should consider establishing a streamlined, standardized process for provider appeals to reduce provider administrative burden.

How this should be accomplished: The OHCA can collaborate with MCOs in development of a process that, at minimum, meets NCQA requirements.

Barriers to standardizing the function: multiple current systems and processes may impede process standardization. The OHCA should collaborate with MCOs and providers to develop a process, and consider adopting a single multi-payer portal to further unify impacted parties.

Multi-payer Portal

Oklahoma Complete Health recommends collaborating with MCOs to offer a multi-payer portal. A multi-payer solution allows providers to access a single web portal across all MCOs for claims and prior authorization requests, thus alleviating burdens associated with multiple log-in IDs and credentials across payers. A multi-payer solution can expand beyond administrative utilities to include clinical utilities (e.g., care plans, care gaps, patient roster, etc.) for providers as well.

How this should be accomplished: The OHCA should collaborate with MCOs to standardize the claims submission and authorization processes.

Barriers to standardizing the function: A multi-payer portal is only effective if all MCOs and providers consistently use it. We recommend the OHCA consider mandating its use for agreed upon processes to achieve the desired efficiencies.

28. How can MCOs best communicate to providers about updates and changes to plan policies?

Communicating to Providers

MCOs can best communicate to providers about updates and changes to plan policies by delivering frequent, relevant provider communication through multiple modalities. Oklahoma Complete Health recommends communicating in person, by telephone, and through online methods such as website and provider portal. MCOs should deliver communications and maximize visibility based upon the importance and urgency of the information. For example, Oklahoma Complete Health recommends MCOs communicate SoonerCare program and policy changes via website pop-ups and magnified through all other channels including “push” and “pull” delivery.

MCOs can also leverage provider associations to provide training, share information on policy or system changes, and gather feedback. MCOs should offer the right amount of technical assistance for providers when they change or update plan policies.

29. How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?

Helping Providers Navigate Plan Administrative Requirements

MCO’s provider engagement efforts should include meeting providers to make sure they understand program requirements, including detailed billing assistance. MCO staff should be readily available to educate providers on required medical record documentation, common billing errors, filing corrected claims, filing claims when Medicare is primary, and the appropriate use of the electronic HIPAA 837 EDI claim file or paper CMS 1500 claim forms.

MCOs should also conduct ongoing claims monitoring to quickly identify and address potential issues and common errors, ensuring that providers know how to submit timely and accurate claims. Ongoing provider education and support should be a key component of developing and maintaining smooth administrative interactions with the MCO.

Provider Support Beyond Contracting and Billing

Oklahoma Complete Health recommends that MCOs offer support through provider services staff, provider orientations, information on their public website and secure provider portal, including the provider manual and clinical practice guidelines. Providers can also benefit from ongoing MCO education through regular office visits to network providers. Outreach should include education about specific programs, services, and technologies offered by the MCO; and individual education sessions to review provider tools and deliver topic-specific education, such as about trauma informed care and SBIRT. Through this approach, MCOs can better retain providers, improve provider satisfaction, and create stable provider networks.

30. What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

As the largest Medicaid managed care company in the country, Centene, and our affiliated health plans, has worked directly with Medicaid agencies on strategies that States can implement to improve quality and outcomes through shared accountability models that reward providers for quality and improved health outcomes.

Our experience includes advancing models for accountable care organizations (ACOs) that enable independent providers to participate on their own or with other providers through aggregator models. Oklahoma Complete Health will bring these and other strategies to the SoonerCare program.

The OHCA should encourage MCOs to collaborate with providers to prepare and help them successfully improve outcomes under customized payment arrangements and advance along the continuum toward greater levels of accountability. By engaging in true partnerships with providers, MCOs can support the delivery of cost-effective, best-in-class care to ensure the health and well-being of members, while also facilitating ongoing provider success.

What The OHCA Can Do to Prepare and Help Providers

Oklahoma Complete Health suggests that the OHCA consider the following strategies to prepare and help providers successfully participate in models that reward providers for quality and improved outcomes:

- **Collaborate with MCOs and providers** in PCMH redesign and strategies for using VBP to integrate BH and SDOH, enhanced care coordination payments, and performance measurement.

- **Allow MCOs the discretion to develop innovative models** that offer all providers an opportunity to participate in VBP and a pathway to advance to more sophisticated risk-arrangements.
- **Encourage MCOs to align VBP and the OHCA quality performance measures** to drive system-wide improvements in health outcomes and quality of care. MCOs should retain flexibility to incorporate unique quality measures as provider quality improvement goals vary.
- **Engage provider associations** in helping to design VBP models and in educating and encouraging provider participation in VBP programs.
- **Facilitate access to timely and actionable data exchange** between MCOs and providers through secure and collaborative platforms such as the Oklahoma MyHealthAccess Health Information Exchange, as well as a single Oklahoma Health Information Network (OKHIN), under development by the OHCA and the Health Information Technology Advisory Board.
- **Work with MCOs and providers to develop standard eligibility criteria** for provider participation in VBP programs (e.g., maintain open panels, etc.).
- **Organize an MCO and provider joint workgroup** to identify barriers, develop strategies, and share best practices to support the delivery system in advancing towards value-based care.
- **Work with MCOs and providers** on ways to address retroactive eligibility and risk adjustment to reduce unpredictability for providers as they enter into VBP arrangements.

What MCOs Can Do to Prepare and Help Providers

An MCO's role in supporting providers in successful VBP models begins with effectively assessing provider readiness and capacity to participate in VBP arrangements. Further, MCOs should develop processes for continuously assessing providers for readiness to move further along the continuum. In addition, MCOs should leverage population health analytics and risk stratification processes to make sure they align with providers that offer the expertise needed to serve members' needs.

MCOs can support providers' success in VBP models with strategies such as the following:

- Share timely, actionable, and accurate data
- Offer education, coaching, tools, and technical assistance
- Provide technology solutions that reduce administrative burden and improve quality
- Offer high touch consultations
- Offer regular feedback to providers
- Design payment models that account for providers' unique needs and challenges

31. How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

Supporting Primary Care Providers

Oklahoma Complete Health recommends MCOs support PCPs in caring for their patients through an extensive provider engagement strategy that includes experienced, field-based staff who provide support services that reduce administrative burden, education and coaching opportunities tailored to their specific needs of the provider, and access to actionable data to drive targeted solutions. This support will enhance care delivery and foster a positive patient-provider experience; allowing PCPs to focus on providing high quality care for their patients.

Infrastructure

Oklahoma Complete Health recommends the following infrastructure supports for PCPs in caring for their patients:

- Comprehensive provider analytics platform, including performance management and population health management tools with actionable and timely clinical and administrative data.
- Education on the use of certified EHRs and HIE for data submission, quality metrics, and care gap closures so providers can connect and are prepared to participate in more advanced VBP arrangements.
- Programming designed to support PCPs in achieving PCMH accreditation
- A Provider Relations team that includes staff with clinical expertise
- MCO support through appointment scheduling and reminders, and care coordination activities to support patients and providers
- Encouraging promotion of MCO programs (e.g., patient incentive programs, perinatal education campaigns) by PCPs to patients
- A framework for delivering virtual care

Programs, Training, and Coaching

MCOs should support PCPs by offering training and coaching that align with the OHCA's payment and delivery system reform goals. This includes a high-touch local engagement strategy that covers training on operational topics such as claims submission and prior authorization, to more targeted trainings specific to the provider, such as leveraging the provider analytics platform to identify opportunities to increase revenue and improve health outcomes. Training and coaching should be accessible and convenient for the provider using a variety of modalities including webinars, in-office training and access to an online educational

resource center. Oklahoma Complete Health recommends MCOs leverage national best practice training experts and Oklahoma's professional community to bring clinically-rich coursework to PCPs with opportunities for continuing education and professional certification.

Network Adequacy

32. How should MCOs work with providers to ensure timely access to care standards are met?

Through Centene's experience as the largest Medicaid managed care organization in the nation, Oklahoma Complete Health recognizes that it is necessary to implement multifaceted strategies to provide timely access to care for Medicaid members. For example, many Medicaid members often require access to after-hours and weekend primary care and clinic availability to accommodate their work schedules. Understanding these nuances, we recommend the following approaches, which reflect ways in which MCOs can work with Medicaid providers to ensure timely access to care. In addition, the OHCA can support MCO efforts by mandating that providers serving SoonerCare members enroll in Oklahoma Medicaid. By doing so, the OHCA promotes provider understanding and adherence to Medicaid access to care standards.

Ensuring Timely Access to Care Standards Are Met

Provider Communication. MCOs should communicate access standards and requirements through vehicles such as the provider contract, provider manual, and provider orientation and training. In addition, MCO network staff should reinforce compliance with these standards during provider office visits and provider inquiries, and offer support upon request, or when program stakeholders identify issues.

Access Monitoring. Routinely monitoring data, such as the following, will ensure MCOs meet timely access to care standards:

- **GeoAccess analyses** to confirm that MCOs execute contracts with the right number and specialty distribution of providers with experience serving Medicaid members. Further, the OHCA should prohibit bidders from deeming Medicare and commercial networks for network adequacy, since these providers may or may not have experience serving Medicaid members
- **Single Case Agreement Requests and Out of Network (OON) Claims Utilization** to identify gaps that OON providers fill, and help identify trends by region or provider type
- **Appointment availability and after-hours access** data to make sure that all Medicaid members have timely and equal access to medically necessary services and their treating providers.

We recommend that the OHCA require MCOs to adhere to the following standards when monitoring appointment availability:

	Standard
Primary Care Appointment Availability	• **Not to exceed 30 days from the date of the member's request for a routine appointment** • **Within 72 hours for non-urgent sick visits** • **Within 24 hours for urgent care**
Specialty Care Appointment Availability	• **Not to exceed 60 days from the date of the member's request for a routine appointment.**

- **Member and provider feedback** through satisfaction surveys and advisory committees to identify access issues that MCOs need to address at the provider or enterprise level
- **Grievance and appeals data** to identify trends in compliance with timely access standards.

Additional Support. In addition to the provider communication and monitoring activities described above, MCOs should support timely access through activities such as assisting members and providers with scheduling appointments and addressing barriers to completing appointments.

33. What are reasonable time and distance standards in Oklahoma by provider type?

Our parent company, Centene, develops and maintains Medicaid provider networks nationwide that offer available and accessible high-quality providers on a 24/7 basis, and meet or exceed appropriate state access and availability standards.

Reasonable Time and Distance Standards in Oklahoma by Provider Type

When developing the following suggestions for reasonable time and distance standards, Oklahoma Complete Health considered numerous factors: geographic and transportation considerations unique to Oklahoma; Medicaid provider participation, availability, and capacity; patterns of care; and the needs of State Medicaid members. Network adequacy standards should acknowledge and account for differences between urban and rural areas and we recommend that the OHCA adopt the following network adequacy standards, including standards for rural areas that are less stringent than those in urban areas:[v]

- **Primary care (adult and pediatric)**: 15 minutes, 10 miles (urban); 60 minutes, 45 miles (rural)
- **OB/GYN**: 15 minutes, 10 miles (urban); 60 minutes, 45 miles (rural)
- **(BH)**: 45 minutes, 30 miles (urban); 60 minutes, 45 miles (rural)
- **Specialists (adult and pediatric)**: 45 minutes, 30 miles (urban); 60 minutes, 45 miles (rural)

- **Hospitals**: 45 minutes, 30 miles with exceptions as needed for rural areas
- **Pharmacy**: 20 minutes, 15 miles with exceptions as needed for rural areas
- **Dental**: 30 minutes, 25 miles (urban); 60 minutes, 45 miles (rural)

We recommend the OHCA permit exceptions to standards where shortages or access issues exist or occur.

MCOs should also be required to demonstrate sufficient Indian Health Services, Tribal, and Urban Indian Clinic Providers (I/T/Us) participation in their network to provide timely access to covered services for American Indians/Alaska Natives, which make up a large percentage of SoonerCare members.

34. How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

Recruiting More Health Care Providers for Medicaid

Oklahoma Complete Health understands the challenges associated with persuading providers to participate in Medicaid and provide care for members. Similar to issues present in many Medicaid markets nationwide, Oklahoma's health care providers often cite administrative burden and reimbursement rates relative to the cost of care as primary reasons for being reluctant to participate in Medicaid.

The successful recruitment of high-quality providers to participate in Medicaid must begin with an actuarially sound Medicaid fee schedule that MCOs can supplement with innovative enhanced payment and/or value-based contracting arrangements.

Further, MCOs should collaborate with providers to reduce the administrative burden often associated with serving Medicaid member. MCOs can accomplish this through approaches such as:

- **Streamlined claims submission and payment processes** that may include use of national EDI clearinghouses for claim submission, online claim submission and status inquiry tools, and Electronic Funds Transfer (EFT)
- **Streamlined administrative functions** such as for eligibility verification, credentialing, and prior authorization requests and status updates
- **Innovative technology platforms and tools** that support efficient practice management
- **MCO support** with appointment scheduling and member outreach and incentives to help reduce no-show rates.

A Medicaid Network for Medicaid Members

At the onset of the new program, the OHCA should require MCOs to recruit, build and maintain a network of providers that have experience with - and understand the nuances of – serving Medicaid members in Oklahoma.

Therefore, we strongly encourage the OHCA to require MCOs to demonstrate that the providers listed in their network have agreed to serve Medicaid member versus deeming their participation. A health care provider's participation in an MCO's Medicare and/or commercial network does not mean that the provider has experience with or is willing to serve Medicaid members.

35. How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

MCOs should support workforce development efforts through solutions that engage educational institutions, policymakers, other MCOs, providers, workers, and Medicaid members across the State. Oklahoma Complete Health recommends creating a multi-stakeholder workforce development taskforce to:

- Conduct workforce analyses
- Identify potential target areas by provider type (including pediatric dentists, pediatric and adult BH professionals and psychiatrists, primary care providers, and specialists)
- Create a workforce development plan that provides creative solutions that MCOs and other entities can support.

Workforce Development Suggestions by Provider Type

Workforce development initiatives that the OHCA should consider include:

- **Educational institution partnerships.** MCOs, in addition to providers and other community agencies, can partner with educational institutions to identify internship and practicum opportunities and expand training programs.
- **Training and support.** MCOs can expand remote training and mentorship programs.
- **Residency program support**. We recognize that it is challenging to recruit and retain providers, especially in rural areas. In response, we propose a workforce strategy that includes supporting residency programs that promote essential workforce training with a primary focus on ambulatory, primary, and preventive care. The strategy can also include

more specialized BH training opportunities for advanced practice nurses and other physician extenders.

- **Expanding use of Community Health Workers.** Community health workers can conduct health risk screenings, provide vital health literacy training, establish a culturally competent link between members and the providers, and deliver essential navigation support to the most at-risk members. Including community health workers as a Medicaid reimbursable service can facilitate increased access to these services and can also support workforce development.

Grievances and Appeals

36. How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

"No Wrong Door" for Obtaining Member Feedback and Addressing Concerns

Oklahoma Complete Health recommends a "no wrong door" policy for obtaining member input and feedback on MCO programs, initiatives, and operations at every member touchpoint. We further recommend that MCOs train all member and provider-facing staff to receive, log, and respond to identified concerns. In addition, we suggest the OHCA require MCOs to solicit and report on member and stakeholder quantitative and qualitative input.

For any comment that rises to the level of a member concern (e.g., issues of accessibility, cultural competency, quality, or safety), we recommend that MCOs train all member-facing staff to resolve the concern, provide assistance, ensure satisfaction, and report the concern in accordance with applicable policies and procedures. MCOs should maintain procedures to respond to time-sensitive concerns (e.g. those around receipt of durable medical equipment [DME], and for those that are systemic or require investigation (e.g. complaints about provider after-hours accessibility). For complete member satisfaction, processes should include follow-up with concerned members to confirm they received all necessary services, that the MCO heard and understands their concern, and valued their insight. All MCOs must have grievance and appeals processes in place that meet federal and the OHCA requirements, including those related to communications and response timeframes.

Accountability and Communication

We recommend that the OHCA work directly with MCOs to develop the most efficient method for maintaining communication on member concerns that come to their attention. In some states, MCOs designate a single dedicated staff person to serve as a liaison to the State Medicaid agency. MCOs often offer technological solutions to speed secure communication with their state clients. Some states elect to create issue-specific task forces with all contracted MCOs to create a unified approach for responding to any broad-based concerns (e.g., enrollment and public health initiatives). To establish accountability, we recommend that MCOs monitor and measure feedback on member concerns and track and trend results as part of a continuous quality improvement process.

Proactive Approaches Improve the Member Experience

Oklahoma Complete Health's organizational philosophy is to identify and resolve issues before they become concerns or complaints. MCOs should have the processes, people, training, and

analytics in place to identify issues proactively, especially as it relates to access and availability of services, population health goals and initiatives, and member services and programs.

We also recommend that MCOs and the OHCA work collaboratively to identify concerns proactively and mutually develop solutions. This collaboration helps minimize the potential of additional members experiencing the same issue and reduces the friction that often develops across stakeholders if members concerns are not promptly addressed.

37. How can the state and MCOs use appeals data to improve utilization management and access?

Using Appeals Data to Improve Utilization Management and Access

Through the experience of our affiliated health plans in 29 states, Oklahoma Complete Health knows that the systematic analysis[2] of appeals data can improve UM and access through enhancements in areas such as:

- General and targeted provider outreach, education, and training
- Clarification of, or updates to, utilization guidelines
- Staff re-training and support
- Network adequacy
- Member education and support

For example, analyses of appeals data may reveal a pattern in denial rates that requires an MCO to update its messaging to providers or conduct individual provider outreach and education on medical necessity criteria or required UM timeframes. Appeals data trends also may indicate the need for MCOs or the OHCA to review, clarify, or update UM policies or guidelines. Analysis of the number of overturned prior authorization denials may indicate the need for additional MCO staff education/training on processes, consistent application of medical necessity criteria, and appropriate documentation, for example.

Appeals data also can help MCOs identify member patterns of care that indicate potential access issues. For example, appeals data related to members consistently accessing non-network providers could indicate appointment availability issues with network providers. A pattern of appeals related to a member accessing services from non-network providers could also indicate the need for additional member outreach and education, during which time MCOs can address other identified issues. For example, staff could help a member find a network PCP that is more convenient to their location or who is more culturally aligned to their background. They also may be able to identify and address other issues that are preventing appropriate

access, such as the need for child care or transportation. Staff can then help link the member to needed community services.

Centene offers more than 35 years' experience working with our State partners to maximize provider confidence and member satisfaction. We comply with NCQA guidelines and State and federal requirements in our Grievance and Appeals processes and data review. Oklahoma Complete Health recommends that the OHCA require MCOs to timely report appeals data to the OHCA and appropriately address identified issues through internal mechanisms such as their quality program. This will help MCOs remain transparent and accountable State partners.

Administrative Requirements

38. How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

Streamlining Data Sharing

A critical success factor in effective care coordination is appropriate and timely sharing of relevant clinical, health, and social service information between and among the OHCA, MCOs providers, SoonerCare patients and their caregivers, and community partners. Data sharing is a rapidly evolving and growing landscape, and MCOs need to continuously seek new ways for efficient, accurate, secure, and timely exchange of health information for meaningful purposes. Due to disparate data sources and varying use cases, it is important that the OHCA and MCOs work collaboratively and continuously to foster data sharing alignment where possible to support provider success and optimize patient health outcomes.

Defining Common Data Standards

To facilitate streamlined data sharing processes that address SoonerCare program requirements, we recommend that the OHCA partner with all MCOs to form a Data Exchange Workgroup. The workgroup would be charged with identifying and finalizing data exchange format and transmission standards that support program needs as well as Oklahoma, the OHCA, and HHS Office of National Coordinator standards. In several cases, we believe MCOs and the OHCA can build upon existing standards such as the OHCA EDI Companion Guides. By finalizing specifics related to data format and transmission exchanges (derived from existing standards), the workgroup will reduce burden on the OHCA and MCOs in their support of streamlined data sharing.

MCO Management Information System (MIS) Architecture Built for Data Sharing

An MCO's MIS should be constructed with secure open industry architectural standards informed by Medicaid Information Technology Architecture principles and integration technologies compatible with the Medicaid MIS and other applications at the OHCA. These properties will facilitate flexible, yet secure and comprehensive, integration capabilities with both the OHCA's systems, providers, and other stakeholders (including patients and caregivers).

Secure Online Portals

SoonerCare MCOs should consider offering secure, web-based online portals for the exchange of data and information to support self-service administrative functions, care coordination for SoonerCare providers, members, and caregivers. For example, through online portals,

authorized provider and MCO users can share member-specific information such as completed screenings and care plans to support care.

Health Information Exchanges (HIEs)

HIEs such as MyHealth Access Network offer an opportunity for improved data integration, interconnectivity, and data sharing among providers, hospitals, the OHCA, and MCOs. For exchanges to be successful, all entities need to contribute data and actively participate. To encourage expanded meaningful data exchange, we support the OHCA's and the Health Information Technology Advisory Board's (HITAB) efforts to define a single Oklahoma Health Information Network (OKHIN), which could accommodate connections and interoperability with existing entities, including HIEs and State of Oklahoma infrastructure.

From our own experience connecting to State and regional HIEs, we have seen that having multiple HIEs with little or no state governance can result in burdensome processes for providers, MCOs and the State. Accordingly, we recommend that the OHCA strongly encourage Medicaid MCOs to participate in a single, statewide HIE, to establish one designated hub of information to promote hospital, provider, and MCO connection and collaboration. MCOs and the OHCA should encourage providers to submit data to HIEs by educating them on the benefits, including greater ability to identify prevalent health conditions, barriers, and disparities to target quality improvement and care and disease management initiatives. We also recommend the OHCA consider a governance model wherein you incentivize health care entities (e.g. MCOs, providers, hospitals, etc.) to participate in the State's recommended HIE and health data sharing plan. By doing so, participants can obtain clinical event alerts, clinical documents, and other information they need to intervene with the patient in the right place at the right time.

Direct Electronic Medical Record (EMR) Connection

We also recommend strategies that include connecting directly to provider EMRs to support efficient clinical data exchanges between providers and MCOs and improve quality while lowering provider administrative effort.

Partner Data

MCOs should investigate additional sources of data such as partnerships with hospital and provider associations. Based on experience in other states, we have found that these organizations can help support clinical data exchange practices, such as serving as the hub for ADTs, and help drive the adoption of best practice clinical data exchange across the State.

Prioritizing Security

Maintaining appropriate privacy and security of patient Protected Health Information (PHI) and Personally Identifiable Information (PII) is of utmost importance. We recommend that MCOs have the infrastructure as well as applicable technical, administrative, and physical safeguards in place to protect patient PHI/PII when exchanging care coordination information. All entities participating in the exchange of information should:

- Implement industry standard security practices such as conducting annual audits and maintaining recognized certifications.
- Apply role based access controls and user profiles to ensure that only those individuals who need PHI/PII to perform their job function can access the information.
- Adopt technologies and processes that follow HIPAA-compliant methods for PHI/PII transmission, as well as other applicable Federal and State laws.

Data to Facilitate Patient Care

A successful SoonerCare Managed Medicaid program will require MCOs and providers to securely share accurate patient demographic information, administrative data (eligibility, benefits, third party resource information), health care service utilization (including pharmacy usage), clinical information (particularly information related to quality measures), and SDOH information. This information needs to be efficiently accessible by both providers and MCOs, with usage in full compliance with State and Federal security and privacy rules and regulations.

39. What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

Data Sharing Barriers

Data sharing for meaningful use of health information is foundational to continued health care transformation, which allows providers and MCOs to better collaborate in care coordination, collect and integrate clinical and social data for population health efforts, and engage in VBP arrangements. To better understand data sharing barriers facing providers, MCOs should employ methods to assess provider EHR and HIE connectivity capabilities, as well as barriers faced in implementing these avenues for sharing data. This includes soliciting input from all provider types, allowing MCOs to better understand barriers to adoption, and implementing tailored strategies that address obstacles experienced by providers. In our experience in other Medicaid managed care programs, we have found that the biggest barriers to data sharing through EHR and HIE technology include:

- No identification or prioritization of impactful use cases

- Insufficient technology resources or focus
- Lack of partnership among entities causing inconsistent data exchange formats or platforms.

Strategies to Overcome Data Sharing Barriers

The key to accelerating data sharing, as well as adoption and meaningful use of technology solutions, is to educate providers and offer them the ability to receive actionable information, displayed in a manner the provider needs (e.g. at the point of care), while also supporting automated workflows that relieve costly administrative burdens for providers. MCOs need to meet providers where they are, technologically, and encourage the use of certified EHRs and HIE for data submission, quality metrics, and care gap closures so providers can connect and share in ongoing cost savings. For providers with limited resources and technology support, MCOs should offer secure web-based services that allow providers to receive and send the information they need to meet SoonerCare's quality and cost objectives.

Educational Tools

MCOs should be structured to promote data sharing awareness and educate providers on the benefits of data sharing. MCOs should also use provider site visits, resources on their public websites, and tailored email alerts to inform providers about data sharing initiatives in Oklahoma, as well as to establish and normalize data sharing use cases and best practices (i.e. using EHRs and connecting to HIEs). MCOs should continuously refine these engagement efforts and tools to respond to provider pain points and newly identified barriers. MCOs also can incentivize providers to adopt EHR/HIE technology as they progress along the VBP continuum as an integrated component of their value-based strategies.

Collaborative Efforts to Streamline Data Sharing

As discussed in Question 38 above, MCOs should take a collaborative approach to encourage data sharing efforts among providers, including HIE participation and EHR utilization. We share the OHCA's belief that improved data integration, interconnectivity, and data sharing between providers, hospitals, and other MCOs will improve care. Working together to define shared data exchange formats, using common platforms to share clinically-relevant data, and promoting participation in a single, state-supported HIE helps to ease provider and MCO administrative burden, and ultimately results in greater health outcomes for patients.

Data Sharing for Members

Perhaps the most important constituent to consider when implementing a data sharing strategy are SoonerCare members and their caregivers. Please see our responses to Question 20 and 21

for our discussion on how MCOs can use technology and other mechanisms to enhance data sharing with members.

40. How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

Identifying Member and Provider Fraud

MCOs are in a unique position to prevent, reduce, detect, and report known or suspected fraud, as well as waste and abuse, while also preventing potential health risks to members. Oklahoma Complete Health recommends that the OHCA require MCOs to maintain fraud, waste, and abuse (FWA) policies and procedures as part of their comprehensive compliance program. MCOs compliance programs and FWA policies should include effective internal and external controls and oversight to safeguard Medicaid funds against unnecessary or inappropriate use of services and against improper payments. To help identify member and provider fraud, the OHCA should recommend MCOs integrate industry-leading prospective and retrospective tools, processes, and technologies that allow for prompt detection and prevention of FWA. Further, MCOs should administer FWA policies in a manner that is efficient and unobtrusive to providers.

Methods of Fraud Prevention and Detection

Oklahoma Complete Health recommends the OHCA consider the following methods and activities for MCOs to prevent and detect FWA.

Prospectively Identifying Fraud. MCOs can proactively identify fraud through the following:

- Third Party Liability (TPL) identification via the enrollment/eligibility file and/or through a separate State TPL file. As a best practice, MCOs should augment TPL information captured from State files by collaborating with national TPL recovery partners who maintain expansive, nationwide databases of insurance eligibility information. Capturing TPL and other insurance information can reduce instances of wasteful spending and enable MCOs to more easily redirect claims to the proper payer, before payment.
- Pre-payment claims edits using code-editing software that enables MCOs to review all claims against coding standards set by the State, the National Correct Coding Initiative (NCCI), the American Medical Association, and medical specialty organizations to ensure alignment. By using a claims processing system capable of applying NCCI edits and pre-payment software tools, MCOs can apply clinical edits to assess claims coding accuracy. Instead of paying providers and then recouping or entering into a settlement, MCOs can stop payment on potentially miscoded claims and take action including, but not limited to educating the provider, placing the provider on full pre-pay review, or opening an investigation. These activities allow MCOs to demonstrate cost avoidance to the OHCA by tracking the dollar amount saved for these claims through stronger internal controls to prevent, detect, and investigate FWA.

Retrospectively Identifying Fraud. MCOs can retrospectively identify FWA through routine data analysis of key utilization metrics (e.g. admissions/1,000 members, inpatient days/1,000 members, inpatient average length of stay, inpatient readmission rates, and prescription drug and lab over utilization) to identify utilization trends and fraud patterns by allegation type, such as overutilization or upcoding. By comparing utilization metrics across MCOs and with Medicaid FFS, the OHCA can identify the efficacy of an MCO's FWA prevention activities.

In addition to analyzing key utilization metrics, Oklahoma Complete Health recommends the OHCA empower MCOs to use extrapolation methodology to hold providers accountable for fraudulent activities. MCOs should follow CMS guidance on how to effectively and efficiently investigate fraud cases, and should the evidence indicate fraud, seek recoupment for the full measure of the overpayment. This enables MCOs to combat fraud more quickly and at a lower cost, while more effectively deterring FWA by increasing the potential cost of engaging in fraudulent, abusive, or wasteful practices.

41. Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

Oklahoma Complete Health has experience with Marketplace through our parent company Centene, however we do not recommend including this as a part of the SoonerCare RFP. We welcome the opportunity to discuss developing a strong Marketplace program with the OHCA in the future.

August 1, 2020

Comprehensive Managed Care for Oklahoma: Vision and Eye Health Recommendation

Thank you for the opportunity to provide stakeholder input from an optometry perspective.

Benefits provided through MCO's:

I recommend that the MCO be responsible for the eye health and vision care (and not subcontracted out to a managed vision care administrator). I believe this will be better for the patient and the doctor. If a vision plan is involved it is likely that the vision plan will try and carve out medical/surgical and vision care. I also recommend that reimbursement is maintained at the MCO level rather than the level of vision benefit administrator.

Quality:

I would recommend performance-based reimbursement. Specifically in regards to patients with diabetes to get annual eye examinations (preferably with no co-pay). The patients we are serving often times have the most difficult time getting to appointments/care, I recommend to incentivize the patient to make scheduled appointments versus punish the doctor for no shows. Performance-based reimbursements should also be considered for Age Related Macular Degeneration and Glaucoma.

Care Management:

The closer aligned to Medicare, the better. I want to point out that eye examinations are far better than screenings.

Provider Payments:

For credentialing, MCOs should not require doctors to participate with other products. MCOs should contract with their network doctors rather than rent networks from subcontractors. Perhaps telehealth should only be contracted for doctors who also provide in person services.

In regards to reimbursement, a minimum would be existing Medicaid rates, and Medicare should be considered as a better comparison.

I specifically recommend that the OHCA enforce nondiscrimination for Medicaid managed care. Title XIX of the Social Security Act includes a nondiscrimination provision for Medicaid managed care organizations. I would also like to note that I would recommend that the plan that the OHCA chooses should not allow optometry to be excluded from the managed Medicaid network when ophthalmologist are included.

As for timely claims, currently OHCA is among the fastest payers. I honestly believe that is a key factor in many providers choosing to work with Soonercare. I would hope that the timeliness would mimic the current quick payment. At the absolute least, thirty days.

Optometry as a profession has worked closely with the OHCA for bare-bones pricing for glasses. I am concerned that a MCO would send out the work out of state. One of key points most recently was keeping the money for glasses in the state and not outside the state. I would like a provision be that the MCO work directly with the doctors (like current Soonercare agreement) versus farming out to third party (especially one out of state). I would recommend that the MCO look at current glasses delivery method that OHCA is using, I believe it to be very economical.

Network adequacy:

I recommend that optometry be identified as primary type of access as opposed to specialist level. I would also recommend time/distance standard for optometry comparable to other type of primary care doctors. MCOs can improve network access by raising reimbursement. I would take the last few years in terms of access and insist that at least that much eye care was provided.

Of note, optometrist are practicing in 64 of the 77 counties and providing eye care access to 98% of the state's population.

Appeals:

I recommend an optometrist review appeals for an optometry appeal.

Administration:

The more optometrists, dentists, physicians, physician assistants, nurse practitioners, etc, sharing data to help the patient, the better.

Thank you for your time.

Sincerely,

Jason Rhynes, O.D.

Chairmain, Oklahoma Health Care Authority Medical Advisory Committee

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?
    - ***The Majority of responses were to make the MCOs prove that they can handle the populations that they serve in phase one and use this approach for each phase of implementation of new populations-providers want to see community engagement of HANS-***
    - ***MCOs believe you should put everyone in at once or at least allow the excluded populations the opportunity to opt in to the MCOs.***
    - ***Oversight and input from ODMHSAS MCOs should be required to contract with CCBHCs/CMHCs***
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
    - ***The majority say the MCOs should cover all populations-***
    - ***Others say to engage stakeholders to determine and the specialty plans want to carve out into specialty plans-***
    - ***The pros of specialty plans are that they cater to a specific need Cons are that it can be difficult to coordinate care***
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? ***Lots of different ideas they include:***
    - ***Transportation options (ride sharing, Lyft, Uber, Logisticare with more flexibility)***
    - ***Make compliance a condition of enrollment***
    - ***Incentives for keeping appointments, annual checkups, no ED visits or IP stays, quit smoking, weight management (healthy weight), face to face engagement activities***
    - ***Collaborative state/MCO approach***
    - ***Technology-interactive apps, text messaging, data analytics***
    - ***In-home service options***
    - ***Care Managers and Pharmacist working together***
    - ***Consider ACOs that are compensated thru shared savings***

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
    - ***Transportation options***
    - ***Telehealth***
    - ***Same day appointments***

  - ***Streamlined and efficient workflow that allows easy communications and data transfer with the providers***
  - ***Scheduling tools***
  - ***HIE***
  - ***Monitor provider access***
  - ***Reduce admin requirements***
  - ***Health literacy-MCOs should be required to learn about their members and the communities they live in***
  - ***Social determinates of health must be considered throughout the lifespan***
  - ***Whole person care programs***
  - ***Building community networks***
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?
  - ***Partnerships between medical and behavioral health facilities***
  - ***HIE***
  - ***Bundle MAR services together for authorization and payment***
  - ***Primary care partnerships with BH***
  - ***Incentive payments for PCP with improved BH outcomes***
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?
  - ***Document that referral occurred and the outcome***
  - ***HIE***
  - ***Tracking tool similar to the one the HANs are currently using***
  - ***Incentivize specialty providers to participate in referral tracking***
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
  - ***Utilize Community Health Centers already in place***
  - ***Requiring screening tools***
  - ***Contract with local OP facilities for treatment and therapy***
  - ***Contract with OPHIC who has a proven model for influencing changes in primary care***
  - ***True community based behavioral health***
  - ***More IP BH services-members should not have to travel across the state for IP BH***
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
  - ***Case Managers***
  - ***Back to school programs***
  - ***Summer health camps***
  - ***Registered dietitians***
  - ***Diabetes educations***
  - ***Lifestyle coaching***
  - ***Home visits***

  - ***In home therapy***
  - ***Care giver support and services***
  - ***Member/caregiver training***
  - ***Transportation***
  - ***Access to healthy foods***
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? ***Yes***
  - ***In urban areas these services work, but are not readily available in most rural areas***
  - ***Incentives for people that drive for these companies***
  - ***Carve out NET- let SooneRide become more innovative and adjust to members needs***
  - ***Transportation for parent and all dependent children***

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?
  - ***Monetize positive outcomes related to member improvement in stratified outcomes measures for specific health care conditions***
  - ***Data sharing so members can see which MCO perform the best***
  - ***Partial withhold for MCOs PMPM***
  - ***Require and incentivize MCOs to utilize existing infrastructure (HealthySteps, HANs, and CHIO's)***
  - ***Pay for Performance should be for above the usual standard- should not be incentivized for standard of care, but for exceptional care***
- What are the most important indicators of MCO performance? Why?
  - ***Improvements in CMS Quality measures***
  - ***Improved member outcomes***
  - ***Stabilized and more predictable health care costs***
  - ***Increased quality and efficiency***
  - ***Provider and member satisfaction***
- What measures of health outcomes should be tracked?
  - ***CMS Guidelines***
  - ***HEDIS measures***
  - ***30/60/90 day recidivism***
  - ***Progress in member goals***
  - ***Reduced ED visits***
  - ***Disparities in health and social outcomes at the state, county, zip code, and provider levels***
  - ***Member satisfaction***

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
  - ***Electronic communication interface***
  - ***Utilization management tools to track outcomes***
  - ***Predictive modeling***
  - ***HIE***

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
    - ***Consistent goals and communication techniques***
    - ***MCOs should be required to provide provider education***
    - ***HIE***
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
    - ***Call in lines to reduce ED visits***
    - ***PCP visits should not have copays (wellness or sick visits)***
    - ***Accessible and available provider network***
    - ***Home based BH***
- How can MCOs improve the management and coordination for members with chronic or complex health conditions?
    - ***Direct communication with providers***
    - ***No co-pays for PCP visits***
    - ***Universal data base***
    - ***Team approach with care coordinators working with members***
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?
    - ***Assign care managers with MCO or with the PCPs office***
    - ***Community health care partners***
    - ***Comprehensive training***
    - ***Take advantage of established social programs in communities***

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
    - ***Member and provider surveys***
    - ***NQFM, NCQA, evidence based and standardized metrics***
    - ***PCP vs ED visits***
    - ***Increased case management engagement***
    - ***Increased PCP visits***
    - ***Medication compliance***
    - ***Patient reported outcomes***
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
    - ***Provider translators in office***
    - ***Bi-lingual staff***
    - ***Language lines***
    - ***Prepare materials in multiple languages***
    - ***Cultural consciousness of community***
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
    - ***Health Apps***
    - ***Telehealth platforms***

    - ***Phone apps***
    - ***Videos***
    - ***Map based resource finder***
    - ***Texting***
    - ***HIE***
    - ***MCOs should consider supplying devices***
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
    - ***Home visits***
    - ***Health fairs***
    - ***TV advertisement***
    - ***Mobile health services***
    - ***Surveys***
    - ***Should consider providing devices***
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
    - ***Surveys***
    - ***Health fairs***
    - ***Mobile apps***
- What tools and resources would help members search for providers? What information should be provided?
    - ***Chat platform***
    - ***Phone***
    - ***Portal***
    - ***Apps***
    - ***Website***
    - ***General information with services available near them***
    - ***Participating providers***
    - ***Links to provider websites***

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
    - ***Reduced non-emergent ED and IP visits***
    - ***CMS, eCQMs, UDS, HEDIS***
    - ***Incentivize moving beyond standard of care***
    - ***Utilizing existing programs***
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- How should MCOs work with providers to ensure timely access to care standards are met?
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  - ***Loan repayment programs***
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- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?
  - ***An interactive feedback system or an online chat system will be an option to address the concerns quicker. Proactive approaches such as one-to-one feedback system which can record feedback immediately after the case-manager contacted the patient can be one of the solutions to address this issue.—frequent auditing***
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  - ***Doing extensive analytical research to find potential risk factors and high-appealing population which will lead to target based management approach can improve utilization management and access.***
  - ***Many MCOs will make changes to PA requirements as a result of appeals filed.***

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- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?
    - ***HIE/EHR***
    - ***All data should be shared***
    - ***CMS Interoperability and Patient Access final rule***
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?
    - ***Password protected/encrypted provider portals***
    - ***HIE***
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    - ***Monitor ED visits***
    - ***Limit # of visits per month***
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    - ***Integrated data system with all transactions***
    - ***Collaboration between State and MCO***
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? ***This felt like a split between I don't know and yes***

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?
    - ***The Majority of responses were to make the MCOs prove that they can handle the populations that they serve in phase one and use this approach for each phase of implementation of new populations-providers want to see community engagement of HANS-***
    - ***MCOs believe you should put everyone in at once or at least allow the excluded populations the opportunity to opt in to the MCOs.***
    - ***Oversight and input from ODMHSAS MCOs should be required to contract with CCBHCs/CMHCs***
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
    - ***The majority say the MCOs should cover all populations-***
    - ***Others say to engage stakeholders to determine and the specialty plans want to carve out into specialty plans-***
    - ***The pros of specialty plans are that they cater to a specific need Cons are that it can be difficult to coordinate care***
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? ***Lots of different ideas they include:***
    - ***Transportation options (ride sharing, Lyft, Uber, Logisticare with more flexibility)***
    - ***Make compliance a condition of enrollment***
    - ***Incentives for keeping appointments, annual checkups, no ED visits or IP stays, quit smoking, weight management (healthy weight), face to face engagement activities***
    - ***Collaborative state/MCO approach***
    - ***Technology-interactive apps, text messaging, data analytics***
    - ***In-home service options***
    - ***Care Managers and Pharmacist working together***
    - ***Consider ACOs that are compensated thru shared savings***

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
    - ***Transportation options***
    - ***Telehealth***
    - ***Same day appointments***

  - ***Streamlined and efficient workflow that allows easy communications and data transfer with the providers***
  - ***Scheduling tools***
  - ***HIE***
  - ***Monitor provider access***
  - ***Reduce admin requirements***
  - ***Health literacy-MCOs should be required to learn about their members and the communities they live in***
  - ***Social determinates of health must be considered throughout the lifespan***
  - ***Whole person care programs***
  - ***Building community networks***
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?
  - ***Partnerships between medical and behavioral health facilities***
  - ***HIE***
  - ***Bundle MAR services together for authorization and payment***
  - ***Primary care partnerships with BH***
  - ***Incentive payments for PCP with improved BH outcomes***
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?
  - ***Document that referral occurred and the outcome***
  - ***HIE***
  - ***Tracking toll similar to the one the HANs are currently using***
  - ***Incentivize specialty providers to participate in referral tracking***
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
  - ***Utilize Community Health Centers already in place***
  - ***Requiring screening tools***
  - ***Contract with local OP facilities for treatment and therapy***
  - ***Contract with OPHIC who has a proven model for influencing changes in primary care***
  - ***True community based behavioral health***
  - ***More IP BH services-members should not have to travel across the state for IP BH***
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
  - ***Case Managers***
  - ***Back to school programs***
  - ***Summer health camps***
  - ***Registered dietitians***
  - ***Diabetes educations***
  - ***Lifestyle coaching***
  - ***Home visits***

  - ***In home therapy***
  - ***Care giver support and services***
  - ***Member/caregiver training***
  - ***Transportation***
  - ***Access to healthy foods***
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? ***Yes***
  - ***In urban areas these services work, but are not readily available in most rural areas***
  - ***Incentives for people that drive for these companies***
  - ***Carve out NET- let SooneRide become more innovative and adjust to members needs***
  - ***Transportation for parent and all dependent children***

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?
  - ***Monetize positive outcomes related to member improvement in stratified outcomes measures for specific health care conditions***
  - ***Data sharing so members can see which MCO perform the best***
  - ***Partial withhold for MCOs PMPM***
  - ***Require and incentivize MCOs to utilize existing infrastructure (HealthySteps, HANs, and CHIO's)***
  - ***Pay for Performance should be for above the usual standard- should not be incentivized for standard of care, but for exceptional care***
- What are the most important indicators of MCO performance? Why?
  - ***Improvements in CMS Quality measures***
  - ***Improved member outcomes***
  - ***Stabilized and more predictable health care costs***
  - ***Increased quality and efficiency***
  - ***Provider and member satisfaction***
- What measures of health outcomes should be tracked?
  - ***CMS Guidelines***
  - ***HEDIS measures***
  - ***30/60/90 day recidivism***
  - ***Progress in member goals***
  - ***Reduced ED visits***
  - ***Disparities in health and social outcomes at the state, county, zip code, and provider levels***
  - ***Member satisfaction***

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
  - ***Electronic communication interface***
  - ***Utilization management tools to track outcomes***
  - ***Predictive modeling***
  - ***HIE***

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
    - ***Consistent goals and communication techniques***
    - ***MCOs should be required to provide provider education***
    - ***HIE***
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
    - ***Call in lines to reduce ED visits***
    - ***PCP visits should not have copays (wellness or sick visits)***
    - ***Accessible and available provider network***
    - ***Home based BH***
- How can MCOs improve the management and coordination for members with chronic or complex health conditions?
    - ***Direct communication with providers***
    - ***No co-pays for PCP visits***
    - ***Universal data base***
    - ***Team approach with care coordinators working with members***
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?
    - ***Assign care managers with MCO or with the PCPs office***
    - ***Community health care partners***
    - ***Comprehensive training***
    - ***Take advantage of established social programs in communities***

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
    - ***Member and provider surveys***
    - ***NQFM, NCQA, evidence based and standardized metrics***
    - ***PCP vs ED visits***
    - ***Increased case management engagement***
    - ***Increased PCP visits***
    - ***Medication compliance***
    - ***Patient reported outcomes***
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
    - ***Provider translators in office***
    - ***Bi-lingual staff***
    - ***Language lines***
    - ***Prepare materials in multiple languages***
    - ***Cultural consciousness of community***
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
    - ***Health Apps***
    - ***Telehealth platforms***

    - ***Phone apps***
    - ***Videos***
    - ***Map based resource finder***
    - ***Texting***
    - ***HIE***
    - ***MCOs should consider supplying devices***
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
    - ***Home visits***
    - ***Health fairs***
    - ***TV advertisement***
    - ***Mobile health services***
    - ***Surveys***
    - ***Should consider providing devices***
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
    - ***Surveys***
    - ***Health fairs***
    - ***Mobile apps***
- What tools and resources would help members search for providers? What information should be provided?
    - ***Chat platform***
    - ***Phone***
    - ***Portal***
    - ***Apps***
    - ***Website***
    - ***General information with services available near them***
    - ***Participating providers***
    - ***Links to provider websites***

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
    - ***Reduced non-emergent ED and IP visits***
    - ***CMS, eCQMs, UDS, HEDIS***
    - ***Incentivize moving beyond standard of care***
    - ***Utilizing existing programs***
    - ***KPI measures for increased PCP visits and reduced no show visits***
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August 17, 2020

Oklahoma Health Care Authority
4345 N Lincoln Blvd,
Oklahoma City, OK 73105

SUBJECT: 80720200002

Thank you for the opportunity to comment on the upcoming Medicaid managed care organization RFP.

This response is made by the Oklahoma Ambulance Association (OKAMA), the organized and unified voice for ambulance services in Oklahoma. Formed in 2000, our membership includes urban, rural, and super-rural emergency medical services (EMS) providers operating across our state. Ground Emergency Medical Transportation (GEMT) providers – including county and other governmental EMS providers, private ambulance providers, and hospital-based EMS services – along with air ambulance providers and various affiliates comprise our ranks.

Should you have any questions about these responses or desire additional information, please contact Greg Reid, OKAMA President-Elect, at GAR281@gmail.com or (405) 613-7443.

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Excluding GEMT and air ambulance providers from the managed care system when conducting 9-1-1 responses and transports would ensure Oklahomans retain access to pre-hospital emergency medical services. Unlike primary care and many hospital-based healthcare providers, GEMT and air ambulance agencies do not know patients' payer sources when dispatched to 9-1-1 calls, as these requests for service are not pre-scheduled. Furthermore, when a patient has suffered serious traumatic injuries, is in cardiac arrest or has unstable vital signs, is unconscious, is under the influence of drugs or otherwise mentally incapacitated, is a minor, or has other special circumstances, frontline providers may not ascertain the patient's payer status until long after transporting the patient to the hospital and transferring his care to a receiving facility. Restrictions related to the response and transport of 9-1-1 patients – including but not limited to approved or preferred hospital emergency room destinations – would be onerous (and in some cases, impossible to satisfy) for frontline providers and dangerous to patient welfare.

Telehealth/use of healthcare navigation lines could help ensure that under-resourced individuals, particularly those with transportation barriers, access the services most appropriate for their immediate medical need without creating onerous restrictions for patients or providers. Too often, individuals call 9-1-1 when they have a non-emergent medical need and either no ability to get to a healthcare facility independently and/or an inability to seek care during customary doctor's office hours.

Oklahoma State Law (§63-1-2504.1) establishes that GEMT has a "duty to act," meaning providers must respond appropriately when called for emergency service regardless of the patient's ability to pay. Due to liability concerns, most Oklahoma GEMT providers follow a strict policy of responding to all requests

for services received via the 9-1-1 system. That is, “duty to act” in practice means responding regardless of the patient’s ability to pay or medical complaint/condition. This results in overutilization of costly GEMT resources.

The downstream effect is even more troublesome. Oklahoma GEMT and air ambulance providers are not reimbursed for their response or care provided to a patient on scene (treatment-in-place) unless they also transport the patient to an approved facility (almost always a hospital emergency department). There is no incentive, and a strong liability risk, for providers to refuse to transport a patient to a hospital.

When GEMT providers transport under-resourced patients to a hospital emergency room, the hospital has a “duty to act” under the federal Emergency Medical Treatment and Labor Act (EMTALA). GEMT is not designed to serve primarily as a method of transportation, nor are hospital emergency departments efficient at or designed to provide care for non-emergent healthcare needs.

The lack of reimbursement for treatment-in-place has been recognized on a national level as a problem impacting patients and healthcare providers, and driving downstream costs. The American Ambulance Association is currently working to draft protocols for administration of safe, reasonable treatment-in-place programs.

Respectfully, our three recommendations are as follows:

1. Exclude 9-1-1 GEMT and air ambulance responses and transports from the managed care system.
2. Expand telehealth into Medicaid. This would allow for managed diversion of non-critical patients to more affordable, appropriate treatment options.
3. Reimburse GEMT providers for treatment-in-place. This should save significant money downstream and preserve the capacity of emergency resources for patients who most need them.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Utilization of ride-sharing services should be expanded in conjunction with the implementation of telehealth/healthcare navigation lines to ensure more appropriate utilization of GEMT and hospital-based emergency services. Patients with non-emergency needs – such as chronic lower back pain, medication shortages, etc. – could be diverted to clinics or other facilities better suited to the patients’ complaints. This would deliver downstream savings and improve care for all Oklahomans by protecting emergency medical transport and treatment capacity.

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TO: Oklahoma Health Care Authority

RE: Request for information on Managed Care program development

In response to the request for information on the implementation of Medicaid Managed Care Program in Oklahoma, WellFirst Health would like to recommend a regional managed care delivery model that has been successful elsewhere and would serve both Medicaid member interests as well as overall tax payer interests in the expansion of Medicaid in Oklahoma. If the RFP process allowed proposals for regional plans, high-quality and efficient local health plans could propose to serve a selected region of Oklahoma without requiring them to build a less efficient statewide network.

WellFirst Health is an insurance entity owned by SSM Health. SSM Health is also the parent company of St. Anthony Hospital that has provided health care to Oklahoma citizens for over 120 years. Along with the physician group and the affiliated hospitals, there is a commitment to Oklahoma at SSM Health.

WellFirst Health has first-hand experience that integrated delivery networks — where physician groups, hospitals and health plans are aligned in care delivery — provide higher quality care at a lower cost. Quality health care is local, and we have experience that the best and most affordable care is delivered through integrated delivery networks (IDNs) that are regionally based. SSM Health operates two regionally based IDNs — one in Wisconsin and one in Missouri.

Additionally, a regional structure for the State managed care program allows more accurate payment models by the State. The capitation payment can then reflect the regional differences in health care costs — whether this is due to critical-access hospitals, availability of after-hours clinics or urgent care facilities, or other utilization or reimbursement differences by geographic area.
SSM Health's Wisconsin-based Dean Health Plan (DHP), has shown the benefits of IDNs to the State Medicaid program. These benefits include:

- Higher Quality
    - We provide exceptional member experience to those who are part of our health plan and access our care delivery network. Of the sixteen health plans that contract with the State of Wisconsin, DHP has consistently been in the top quartile on the State's quality ratings that include HEDIS and HEDIS-like measures. Regional health plans with integrated delivery models typically make up the highest quality health plans for BadgerCare, Wisconsin's family Medicaid program.
    - We help make health care easier for our members because of the close alignment between SSM Health and the health plan. The IDN enables fewer handoffs and more continuous care by providers. One example of a tangible difference in coordination of care are the health plan care managers embedded within clinics / hospitals, working alongside the care delivery team.

    - We have financial alignment with our care delivery network to ensure high quality, affordable care. The IDN allows for the financial risk of the members to be jointly born by the medical providers and the insurance entity, allowing surpluses and deficits in medical expense to be shared.

- More Seamless Administration and Member Experience
    - Consumer experience is enhanced through the IDN where the insurance and care providers are fully aligned in providing the best possible experience for the member / patient. For example, Grievance and Appeals for regional health plans are much lower than national health plans. In Wisconsin, the national for-profit health plans have ten times the number of grievance and appeals than regional health plans, according to reports produced by Wisconsin Medicaid.
- Access to Care
    - We can ensure timely access to care through the regional IDN model. A regional IDN can provide better access to all providers — including specialty providers — through better communication and coordinated care between primary care providers and referred specialists.

Thank you for the opportunity to provide input into the upcoming Medicaid Managed Care Program RFP process and your consideration of a regional model.

Truly,

Les McPhearson
President
WellFirst Health

wellth

August 11, 2020

Re: RFI Response
Reference Number: 80720200002

Wellth supports the Oklahoma Health Care Authority's (OHCA) proposal to select Managed Care Organizations (MCOs) to advance its goal of improving health outcomes, increasing access to care, and increasing system accountability in the SoonerCare program. We appreciate the opportunity to provide input in response to OHCA's RFI and welcome an opportunity to discuss further.

RFI Section: Enrollees
How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Managed Care Organizations (MCOs) can best engage individuals in managing their health care and healthy behaviors through strategies that educate and empower members. MCOs should leverage tools that use behavioral economics to help members develop the skills and habits needed to take control of their health.

Several states have already encouraged Medicaid MCO's to leverage behavioral economics and member incentives into their benefit plans, such as:

Louisiana: The LDH states "LDH is exploring how best practices in healthcare design, through the lens of behavioral economics, can be applied in Medicaid to drive behavior change, leading to improved health, closed care gaps, and optimize spending....**Behavioral economics recognizes that human behavior is irrational and can be influenced, or nudged, through the presentation of choice, framing of messages and design of financial rewards**. Proven behavioral economics principles point to new methods for facilitating, engaging, and helping enrollees across all payer types engage in healthy behaviors.[i]"

August 11, 2020

Wellth is an example of an evidence-based behavioral economics solution that MCOs can use to help Medicaid members improve healthy behaviors including through better diabetes and hypertension management. Our program applies financial incentives and habit science through a scalable mobile application to motivate adherence to daily medications and healthy behaviors. To-date, Wellth has achieved an average daily adherence of 89% (with populations that were previously below 80%) across programs that include the highest-risk Medicaid, dually eligible, and co-morbid populations. We accomplish this through application of behavioral economics strategies including daily loss aversion financial incentives, contextual and personalized nudges, and intuitive and quick photo "check-ins" for daily medications and other healthy behaviors.

To best support MCOs ability to influence member behavior change, including through strategies that utilize behavioral economics, we suggest OHCA implement flexible incentive programs that give MCOs the opportunity to tailor programs to best impact their members' health.

For questions and/or a response, please contact:

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VP of Market Development at Wellth
kristin@wellthapp.com
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12211 Washington Blvd.
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Los Angeles, CA 90066

[i] "Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care" The Bureau of Health Services Financing, Louisiana Medicaid. March 1, 2018. Page 5, Section III.

GT Independence
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877.659.4500 www.gtindependence.com

Your life. Your choice.

August 11th, 2020

Oklahoma Health Care Authority (OHCA)
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Reference: 80720200002 Public Feedback in Program Design

Dear SoonerCare Comprehensive Managed Care Program Team,

This letter is intended to serve as a formal response to your request for public feedback for the SoonerCare Comprehensive Managed Care Program in Oklahoma. GT Independence's mission is to serve participants by providing everyone the opportunity to manage their services and supports through Self-Direction and with the support of a Fiscal Employer Agent (F/EA).

The purpose of this public feedback is to communicate the importance of including Self-Direction with the support of a Fiscal Employer Agent (F/EA) option and inclusion of (EVV) Electronic Visit Verification when designing the Oklahoma's SoonerCare Managed Care system.

Managed Care Organizations need to include Self-Direction with Fiscal Employer Agent

It is our position that all Managed Care Organizations should provide the choice for participants to Self-Direct their services in all their plans.

Managed Care Organizations need to provide participants with "a choice" on how to receive their support and services. When participants are allowed the choice to select Self-Direction, they will be able to choose their care providers and related services that best align with their individual care plan. Studies have shown that participants in a Home Community Base Setting who self-direct their care feel more confident and independent. The elderly for example; increase their confidence levels when self-directing care at home.

Managed Care Organizations with Self-Direction along with a fiscal employer agent (F/EA) choice is a necessary component which will support the person-centered healthcare approach to Medicaid healthcare objectives while providing the participant to take control of their own care with transparency and integrity.

Benefits of Self-Direction

When participants are provided with a choice to Self-Direct their Medicaid services, they have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The addition of a fiscal employer agent (FE/A) support is one of these critical and important supports elements.

Another benefit to Self-Direction is the ability to ensure the services are person-centered as opposed to the traditional service delivery system. When Self-Direction is provided as a choice, every element of support is driven by a person-centered approach to healthcare by ensuring all services are tailored to the needs of the participant. In doing so, participants are provided with the ability to receive more services for the same amount of money, since participants will be able to hire their own care providers and therefore can negotiate a rate of pay which are driven by their own decision authority.

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Self-Direction option addresses the healthcare shortage dilemma. There is a national shortage of healthcare providers nationally, thus creating challenges to individuals needing services within their reach. With Self-Direction as an option, participants may be able to hire their spouse, family member, a legally responsible person or an authorized person who lives nearby to meet some of their needs without interruption and delay of care. Moreover, if a participant lives in a rural area, home care agencies may have a difficult time recruiting staff, since a provider might have to drive long distances to get to some homes. A Self-Directed program option is the perfect solution to the healthcare shortage.

Self-Direction with EVV Compliance (Electronic Visit Verification)

A Self-Direction option with an EVV (Electronic Visit Verification) compliant solution ensures key data elements such as the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends are captured at the time of visit to ensure compliance with the 21st Century Cures Act. A major benefit with an effective EVV solution is its ability to identify gaps in the areas of fraud, waste, and abuse.

Another key benefit of EVV include but not limited to; reduced missed visits and late shift starts, improve overall participant care and outcomes, reduced paper documentation traditionally associated with visit verification and increase productivity and efficiency among healthcare providers.

GT Independence addresses EVV

In 2019, the 21st Century Cures Act passed, requiring all caregivers to use electronic visit verification (EVV), a six-step process required for every care visit. Rather than wait for the new law to be federally enforced in January 2019, GT Independence moved forward to go paperless and streamline the EVV process. GT Independence developed an application called The Caregiver App. The Caregiver App was specifically designed for self-directed services and boasts the highest rating amongst similar applications. With the passing of the 21st Century Cures Act, GT conducted 18-months of intense research and demonstration of existing available EVV systems. To date, in 2020 GT has processed over 2 million shifts which have been submitted by employees of participants being served with our Caregiver Application.

In closing, GT Independence is grateful for the opportunity to provide public feedback regarding the SoonerCare Comprehensive Managed Care Program in Oklahoma. We look forward to the continued collaboration of work which results in the empowerment of the participants receiving waiver services in all Managed Care Organizations.

We welcome any opportunity for questions and or conversations you wish regarding EVV and Self-Direction.

Managed Care Organizations need to include Self-Direction with Fiscal Employer Agent as a choice.

Thank you,
Bill Perez
Regional Director of Business Development
786-570-0647

August 17, 2020

Mr. Kevin Corbett, CEO
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: Response to SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (Reference: 80720200002)

Dear Mr. Corbett:

Thank you for the opportunity to provide input as the state considers moving Medicaid services to a managed care approach.

Nurse-Family Partnership (NFP), also known as Children First in Oklahoma, has over 40 years of evidence showing reduced maternal and child mortality through healthier pregnancies and birth outcomes, and demonstrating significant downstream cost savings to Medicaid. NFP has been – and continues to be – grateful for the opportunity to partner with Oklahoma as a public health nursing benefit designed to improve outcomes for first-time, high risk pregnant women.

Currently, NFP/Children First receives modest Medicaid reimbursement for nursing assessment and targeted case management services via contractual relationships with the Oklahoma State Department of Health and local health departments. Annual Reports show the positive impact these services have on improving maternal infant health and life outcomes. But not all first-time pregnant women have access to these services.

We are pleased to see the SoonerCare goals address maternal health and infant mortality, as well as strategies to address social determinants of health. NFP looks forward to working with Oklahoma to address current unmet need, whether through modifications of the existing structure, or through the adoption of a managed care approach.

Regardless of how the Medicaid program is structured, NFP is committed to standing with Oklahoma on the front lines of prevention efforts. NFP nurses use their skill and expertise to detect early warning signs of health problems during pregnancy, post-partum, infancy, and early childhood that can lead to adverse outcomes.

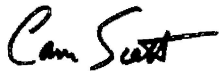
NFP nurses assess for health-related behaviors that compromise fetal development (smoking, alcohol, opioid use, etc.) and encourage women to seek office-based care before conditions worsen. In addition to monitoring for and addressing risk factors, NFP nurses support mothers to advocate for themselves and their children as they interact with the health care system.

NFP nurses impact the social determinants of health of mothers and babies by helping mothers determine and set goals around healthy relationships, education, child welfare and development, employment, health, transportation, diet, and housing. By the time moms graduate from the NFP program they have the tools to set goals, take action, and seek resources needed to continue on a path to a better future for themselves and their children.

We appreciate the opportunity to reflect on the questions posed in the RFI. As part of Oklahoma's current health care services structure, NFP is committed to staying engaged in crafting the strongest, most cost-effective approach to serving more Medicaid-eligible moms and their families at a critical time in their lives. NFP nurses are uniquely trained to address the issues and goals identified in the RFI, supporting significant improvements in their health and their lives as a whole, and generating cost savings for the state by preventing unnecessary downstream Medicaid expenditures.

Please do not hesitate to contact me if you have any questions.

Sincerely,



Cam Scott
Government Affairs Manager, West Region
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Nurse-Family Partnership: Outcomes, Costs and Return on Investment in Oklahoma

Nurse-Family Partnership® (NFP) offers significant benefits to the families it serves and significant cost savings to society and government funders. Based on a review and analysis[1] of **more than 40 NFP evaluation studies**, **including randomized controlled trials, quasi-experimental studies and large-scale replication data**, Dr. Ted Miller of the Pacific Institute for Research and Evaluation predicts that when NFP achieves scale in Oklahoma, it can produce the following outcomes:

- Smoking in pregnancy ↓25%
- Pregnancy-induced hypertension ↓33%
- Closely spaced births (15 months postpartum) ↓25%

- Emergency department use for childhood injuries ↓34%
- Full immunization ↑14%
- Language delay ↓41%

- First pre-term births ↓15%
- Infant mortality ↓48%
- Moms who attempt breastfeeding ↑12%

- TANF payments ↓7% (13 years post-partum)
- Person-months on Medicaid ↓8% (15 years post-partum)
- Costs if on Medicaid ↓13% (through age 18)

NFP's Cost Savings and Return on Investment

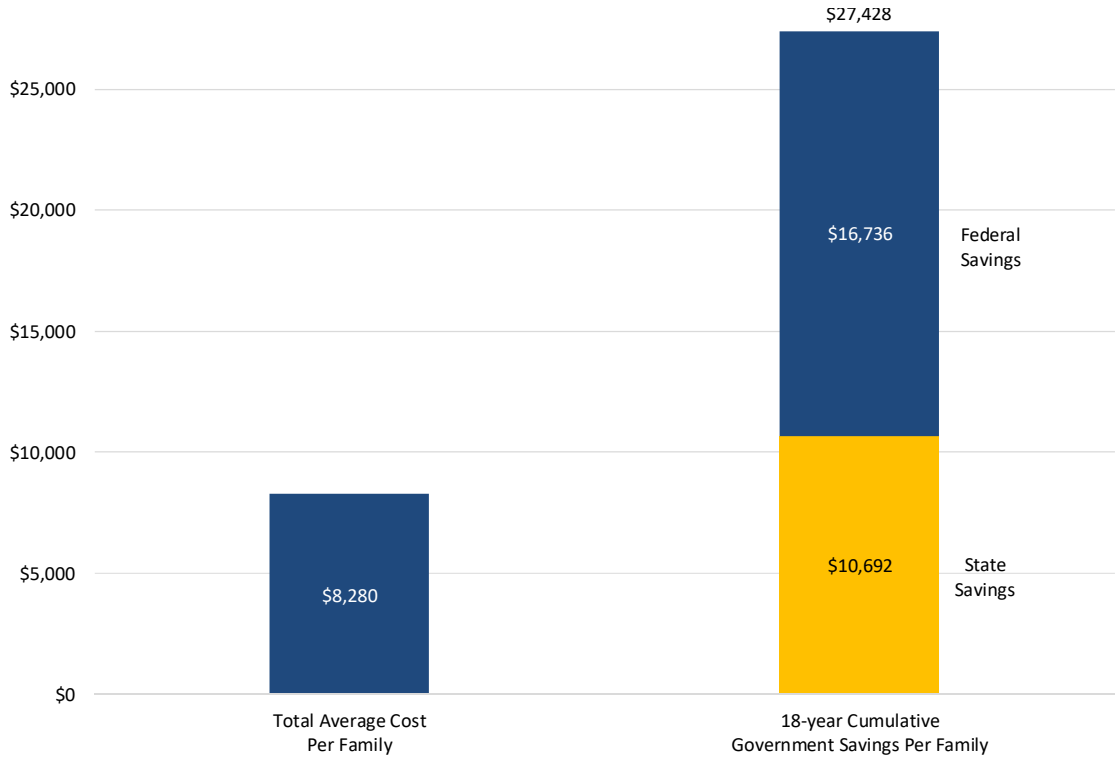
At a total average cost of **$8,280 per family in Oklahoma** (over an average enrollment of 527.2 days,[2] present value at a 3% discount rate, see Figure 1), Miller's model predicts that by a child's 18th birthday:

- State and federal cost savings due to NFP will average **$27,428 per family served** or **3.3 times** the cost of the program.
- Analyzing broader savings to society, Miller takes into account less tangible savings (like potential gains in work, wages and quality of life) along with resource cost savings (out-of-pocket payments including savings on medical care, child welfare, special education, and criminal justice) to calculate:
    - NFP's total benefits to society equal **$63,689 per family served**
    - This yields a **7.8 to 1** benefit-cost ratio for every dollar invested in Nurse-Family Partnership.

[1] Miller, T.R. (2015). Projected outcomes of Nurse-Family Partnership home visitation during 1996-2013, USA. *Prevention Science*. 16 (6). 765-777. This fact sheet relies on a state-specific return on investment calculator derived by Dr. Miller from published national estimates to project state-specific outcomes and associated return on investment. The calculator is revised periodically to reflect major research updates (latest revision: 12/22/2018).

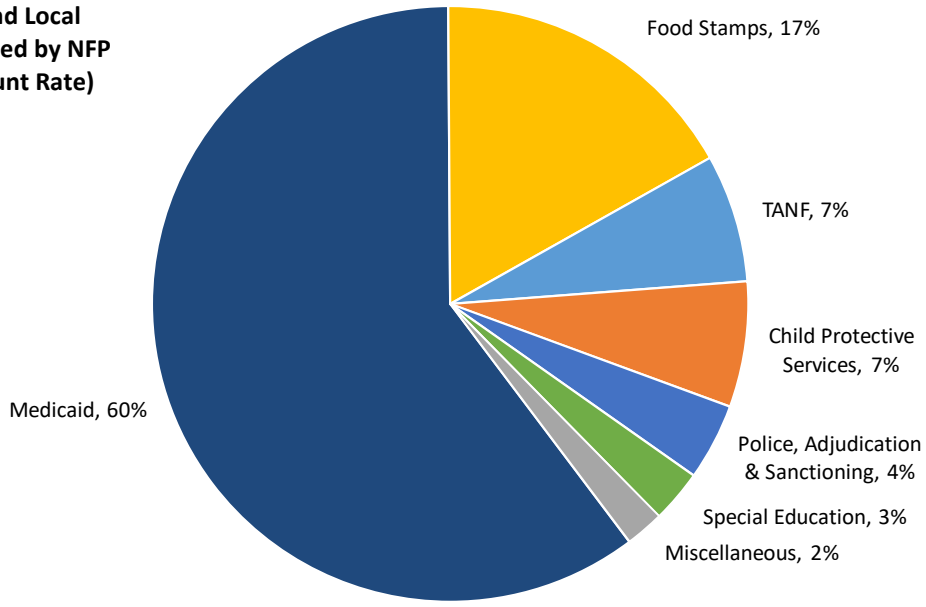
[2] In Oklahoma, the average cost to serve a family for a year is $5,733 (2017 dollars).

Figure 1: Total Average Per-Family Cost and Estimated Government Savings of Nurse-Family Partnership Implementation in Oklahoma (Present Value at a 3% Discount Rate)



Nationwide, Medicaid will accrue 60% of the government cost savings per family served by NFP. If Medicaid fully funded NFP in Oklahoma, each level of government would reap Medicaid savings that exceed its share of undiscounted NFP costs when the child was age 5. By the child's 18th birthday, Medicaid would recoup $2.80 per dollar invested (undiscounted).

Figure 2: Distribution of Federal, State, and Local Government Cost Savings per Family Served by NFP Nationwide (Present Value at a 3% Discount Rate)



August 21, 2020

Oklahoma Health Care Authority
4345 N Lincoln Blvd
Oklahoma City, OK 73105
Sent via email: Procurement@okhca.org

Re: SoonerCare Comprehensive Managed Care 80720200002

The Oklahoma Nurses Association is the voice for registered nurses representing almost 50,000 registered nurses in Oklahoma. Our nurses provide compassionate care for Oklahomans from conception to grave. We represent more health care providers across more settings than any other health care organization, from offices, to schools, to universities, to Armed Services, to hospitals, to birthing centers, to corrections, to juvenile services, to mental health, to home health, hospice, nursing homes, long term care and clinics. As the largest group of health care providers in the state, we stand in opposition to the current proposal for Managed Care Organization (MCO) RFI.

COST

The Oklahoma Health Care Authority (OHCA) already demonstrates its ability to oversee a cost-effective, economical Medicaid program that improves member outcomes. At a rate of only $6,000 per recipient annually over the last five years, Oklahoma already ranks among the least expensive Medicaid programs in the nation, and the second lowest in the region. The state is simply charged with delivering a cost-effective service. In an MCO model like the one proposed, insurance companies who serve as the MCOs, have but one primary goal: profit. That profit is generated in increased costs to the taxpayer and in reduced access to needed care. It has been estimated that if Oklahoma adopts an MCO model of Medicaid Managed Care, Oklahoma will need to increase taxes by up to 3 billion dollars to cover the additional costs. Texas has paid insurance companies $22 billion per year to manage their Medicaid Managed Care program, while the insurers routinely denied vulnerable children care with dire consequences. https://www.dallasnews.com/business/health-care/2019/05/14/pain-profit-hope-remains-for-fixes-to-texas-broken-medicaid-system-but-biggest-tweaks-are-likely-dead/ . Iowa's Medicaid costs tripled following privatization, while many of their enrollees lost access to care. In Illinois, privatization cost the state $10.7 billion dollars, yet hospitals were repeatedly denied legitimate claims for treating Medicaid enrolled patients, while the insurers made their profits.

While Medicaid privatization has been promoted as a means to control costs and save money, experience in other states has demonstrated that the long-awaited cost savings often never arrive. The high administrative costs and built-in profits of privatized programs do not save money or improve care. Rather, they achieve financial success by limiting care and denying services.

INFRASTRUCTURE

The ongoing COVID-19 Pandemic and economic downturn is expanding Medicaid rolls, stressing an already fragile healthcare infrastructure. Oklahoma already has a shortage of registered nurses as we are below the national average of 1,150 RNs per 100,000 with only 700 RNs per 100,000. Our nurses are already spread thin as they work to provide care to Oklahomans in multiple diverse care settings across the state.

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According to In the Public Interest, "multiple states have had ongoing problems with Medicaid Managed Care, with contractors routinely denying or delaying payments to medical providers that serve Medicaid patients." A survey of over 400 Iowa physicians, hospitals, clinics and not-for-profit healthcare providers found that the insurers operating as MCOs were not paying most Medicaid providers on time. The survey also found that because the insurance companies were increasing their administrative costs, providers were forced to reduce the quality and quantity of services they provided.

Results from a survey that included over 400 Iowa doctors, hospitals, local clinics, and nonprofit health care providers found that the majority of Medicaid providers weren't being paid on time by the insurance companies and their administrative costs were already increasing under the privatized system. As a result, many providers reported that they had to reduce the quantity and quality of services they provided. These problems ultimately hurt Medicaid recipients. Nurses are particularly concerned about this pattern of behavior since low and untimely reimbursement affects registered nurses specifically as they do not direct bill for services, but are embedded in health care services such as room rates. Low reimbursement rates negatively affect nurse staffing and salaries. Oklahoma is already struggling with nurse staffing shortages.

According to the American Nurses Association, "Nurses salaries and benefits are among the largest components of a hospital's expenses, and thus are an easy target when balancing budgets." According to the ANA white paper on staffing, "Reducing nurse labor costs may be viewed as a viable solution to resolve cost issues but can have a negative impact on care delivery and outcomes and ultimately jeopardize reimbursement. Nurses currently represent the largest clinical subgroup in hospital systems, at approximately 40 percent of operating costs. Reducing the number of nurses employed by a hospital system may be an attractive solution to reduce labor costs in the short term, but can have unintended negative clinical quality and financial consequences for patients and providers in the long term."

OUTCOMES

While Oklahoma has a few thousand on waiting lists for the disabled, Kansas has tens of thousands on waiting lists for in home care, despite a cost that is nearly $3,000 per recipient higher than ours.

In a 2017 report by Iowa's Managed Care Ombudsman Program, it was reported that the office had received more than 1,800 complaints related to the reduction, denial or termination of Medicaid recipients' services. Delayed payments in Iowa put lives at risk, and in some cases resulted in death. It was reported that one Iowan who relied on a ventilator was no longer able to remain in her nursing home since that facility could no longer accept patients on ventilators due to the insufficient and untimely payments by the private insurers administering the state's Medicaid program. The woman ultimately died shortly after she was moved to a temporary facility in fall 2017. It was reported that as a result only six of Iowa's 417 nursing homes continue to accept ventilator patients.

The drive by privatized Medicaid to reduce costs will result in the reduction of critical nursing staff, as described in the "Infrastructure" section of this document. Reduction in staff will have a significant and deleterious impact upon outcomes. A 2007 study conducted by researchers at Columbia University School of Nursing in New York found that patients have improved outcomes when the ratio of registered nurses to patients is high.

The study found that the risk of mortality was decreased by 81 percent and risk for other conditions like bloodstream infections, pneumonia and bedsores, was reduced when the ratio of registered nurses to patients was higher. The authors pointed out that significant reductions in nursing staff could lead to more medical complications and longer hospital stays.

Other states that have contracted with private MCOs are experiencing increased costs to Medicaid, reduction in services to patients and access to providers. Iowa has yet to demonstrate any cost savings from privatization. Many Oklahomans already experience these issues especially in the case of certain diagnosis and treatment plans. We don't need to compound the problem by privatizing Medicaid.

While some state leaders may believe that other state Medicaid programs were enhanced by outsourcing to private MCOs, we believe the situation and experience in Oklahoma will be very different. Currently, Oklahoma's costs for these services are already lower than those states that contract with private MCOs. It is our hope that the Oklahoma Health Care Authority will reconsider issuing an RFP for privatizing MCOs.

Both Iowa and Kansas have endured reductions in care, saved far less revenue than anticipated, and have sacrificed needed oversight and transparency, by placing their Medicaid programs and enrollees in the hands of private profit-motivated entities. Oklahoma experienced these problems with privatized Medicaid programs in the 1990's, and states surrounding us continue to experience these issues today, demonstrating that this approach inevitably involves high administrative costs while often failing to save money or improve outcomes. The powerful motivation for for-profit insurance companies to limit care and deny services is intrinsic to the MCO model, because the less care they deliver, the greater their profits.

CONCLUSION

Members of the Oklahoma Nurses Association believe that a healthy Oklahoman is a productive Oklahoman. We oppose the MCO(RFI) because it will ultimately limit access to care with adverse outcomes for the health of many thousands of Oklahomans, while increasing the costs to the taxpayer. Not only will those covered by Medicaid experience the detrimental consequences of management by a for-profit insurer, healthcare infrastructure and the available nurse workforce to treat all Oklahomans in every setting across our state will be negatively impacted.

Regards,

Jane Nelson, CAE
Chief Executive Officer
jnelson@oklahomanurses.org

SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design

Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid
- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting
- MCOs will serve members across the state

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?

Initially excluded populations should be added after stakeholders gain managed Medicaid experience with children, low-income parents, pregnant women, and adults ages 19-64. It is important that initial kinks are worked out for these populations first.

Since MCO's have not been a part of Oklahoma Medicaid for many years, these initial populations will need to become familiarized with the new system. Ideally, they will be matched with their historic provider of services, unless they knowingly choose another.

Matching with their historic provider best ensures continuity of care. To best facilitate matching accuracy, historic Medicaid providers should be allowed to submit their Medicaid patient lists to OHCA for assignment to their participating MCO(s), especially for traditional safety net providers such as FQHC's that are already providing services for a high percentage of these populations.

Further, members should be allowed to change plans monthly, to correct any assignment inaccuracies and ensure continuity of care. If a member inadvertently chose the wrong plan or was incorrectly assigned, that member could be reassigned to the correct plan the following month. This prevents a member from being locked into an inappropriate MCO for an extended period of time before reassignment due to an inaccurate initial assignment.

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

All MCO's should be willing and capable of eventually providing all services to all populations when it is appropriate to provide such serves or serve such populations.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

OHCA could save administrative cost by eliminating the MCO "middle man" and contracting with experienced ACO's directly to improve quality and outcomes and reduce cost. But this would require a contracting process through a separate "ACO Track" outside the "MCO Track" utilizing OHCA's current fee-for-service system, as opposed to bidding a member premium.

OHCA's administrative cost is reduced because ACO's are compensated through Shared Savings (SS). OHCA does not need to assume actuarial costs to develop an actuarially sound member premium. OHCA only needs to secure federal waivers to pay SS under a Medicaid ACO model, as several states have already implemented.

Experienced ACO's already engage their attributed (assigned) individuals to encourage healthy behaviors through programs such as the Medicare Shared Savings Program (MSSP).

Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers
- Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

OHCA could save administrative cost by eliminating the MCO "middle man" and contracting with ACO's directly to improve quality and outcomes and reduce cost. But this would require contracting through a separate "ACO Track" outside the "MCO Track" utilizing OHCA's current fee-for-service system, as opposed to bidding a member premium.

Experienced ACO's already enhance service provision to their attributed (assigned) individuals to improve health outcomes, prevention and member satisfaction through programs such as the Medicare Shared Savings Program (MSSP).

- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as **state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**
- MCOs will **reimburse providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions
- **OHCA is investigating the use of incentive measures, quality pools and other programs;** MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?

The state should require MCO's to contract with Accountable Care Organizations (ACO's) and other provider entities with experience in providing high quality care in an efficient manner.

The OHCA could save administrative cost by eliminating the MCO "middle man" and contracting with ACO's directly to improve quality and outcomes and reduce cost. But this would require contracting through a separate "ACO Track" outside the "MCO Track" utilizing OHCA's current fee-for-service system, as opposed to bidding a member premium.

OHCA's administrative cost is reduced because ACO's are compensated through Shared Savings (SS). OHCA does not need to assume actuarial costs to develop an actuarially sound member premium. OHCA only needs to secure federal waivers to pay SS under a Medicaid ACO model, as several states have already implemented.

- What are the most important indicators of MCO performance? Why?
- What measures of health outcomes should be tracked?

Care Management and Coordination

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- **Conduct health screenings** to identify ongoing need, current providers, and social determinants of health
- **Develop care plans** for identified enrollees and **establish care management and care coordination** based on identified risk and particular health conditions
- **Design health management programs** with a holistic approach to member health
- **Conduct health education** in priority areas and on emerging issues

In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
- How can MCOs improve the management and coordination for members with chronic or complex health conditions?

MCO's should contract with ACO's and other provider entities experienced in managing chronic or complex health conditions. This ensures members experience PCP whole person health management that is not discontinued upon member referral.

- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- **Answer member questions timely** via telephone or email and resolve grievances and appeals timely
- **Frequently update provider directories** online to help members locate health care providers
- **Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
- What tools and resources would help members search for providers? What information should be provided?

Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

The State Plan and MCO contracts should include language requiring MCO's compensate FQHC's their Medicaid PPS rate or an Alternative Payment Methodology (APM) at least equivalent to their Medicaid PPS rate, if the FQHC being compensated agrees to the APM.

- What is appropriate for timely payment of claims?

MCO contracts should include language requiring MCO's to mirror OHCA's current timely payment performance.

- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?
- How can MCOs best communicate to providers about updates and changes to plan policies?
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

MCO's should be prepared to share claims data and meet with providers to review that data regularly and often. This allows providers to plan their course of treatment throughout the year to increase quality, improve health outcomes and eliminate unneeded costs.

The OHCA could save administrative cost by eliminating the MCO "middle man" and contracting with ACO's directly to improve quality and outcomes and reduce cost. But this would require contracting through a separate "ACO Track" outside the "MCO Track" utilizing OHCA's current fee-for-service system, as opposed to bidding a member premium.

OHCA's administrative cost is reduced because ACO's are compensated through Shared Savings (SS). OHCA does not need to assume actuarial costs to develop an actuarially sound member premium. OHCA only needs to secure federal waivers to pay SS under a Medicaid ACO model, as several states have already implemented.

- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

The response to the preceding question best supports Primary Care Providers (PCP's).

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

- Examples of industry standards include:
  - Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
  - Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care

- Require all Primary Care Providers have at least some same-day acute care appointments
- Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)

- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?
- What are reasonable time and distance standards in Oklahoma by provider type?
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?
- How can the state and MCOs use appeals data to improve utilization management and access?

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- **Gain accreditation** by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- **Maintain an Oklahoma presence,** including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- **Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

OHCA should mandate MCO's contract with willing ACO's and similar providers with Value Based Contract (VBC) experience on a VBC basis. OHCA should mandate that MCO's provide complete and detailed utilization data for all services provided to the MCO members assigned to the ACO or similar provider, including hospital and other facility, professional and ancillary. This allows the ACO or provider entity to change course of treatment throughout the year to maximize quality and care and minimize unneeded costs of assigned members.

If OHCA were to develop a separate "ACO Track", OHCA could provide ACO's with all utilization data for members under the ACO's attribution (assignment to ACO) directly.

- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?

August 17, 2020

VIA ELECTRONIC SUBMISSION

Oklahoma Health Care Authority
Federal Authorities Unit
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Submitted electronically via procurement@okhca.org

Re: Planned Parenthood Great Plains Comments on SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (Reference Number: 80720200002)

Dear Director Corbett,

Planned Parenthood Great Plains (Planned Parenthood) submits these comments regarding the Oklahoma Health Care Authority's (OHCA) request for public feedback for finalizing the SoonerCare Comprehensive Managed Care Program request for proposals (RFP).

Planned Parenthood is a safety net provider for the populations in Oklahoma most in need of health services. Planned Parenthood operates three health centers across the state of Oklahoma and serves as a leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people. Our health centers are located in Edmond, Oklahoma City, and Tulsa, serving Oklahomans from diverse zip codes. In 2019, our health centers provided affordable birth control, lifesaving cancer screenings, testing and treatment for STDs, and other essential care to nearly 10,000 patients. The vast majority of Planned Parenthood patients have low incomes and 43 percent lack health insurance, and nearly a third of our patients use Medicaid to access our health services.

Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for 63.9 million individuals with low incomes across the country.[1] SoonerCare, Oklahoma's Medicaid program, covers more than 785,000

[1] *Medicaid: December 2019 Medicaid and CHIP Enrollment Data Highlights,* Centers for Medicare and Medicaid Services (2019), available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

Oklahomans,[2] 58% of whom identify as female.[3] Further, approximately 1 in 5 women of reproductive age use Medicaid nationwide. The program is the largest single payer of reproductive health care coverage,[4] paying for 75 percent of family planning services.[5] And for nearly half of women giving birth, Medicaid is the source of coverage for essential care, including prenatal and delivery care; in fact, in Oklahoma, recent data found that Medicaid pays for 58% of all births.[6]

Because women make up the majority of Medicaid enrollees, they will be disproportionately affected by any change in Medicaid program design, including converting the program to managed care. Of particular note, due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population; 31% of Black women and 27% of Hispanic women use Medicaid as opposed to 16% of white women.[7] Moreover, already a majority of women of reproductive age enrolled in Medicaid are enrolled in managed care arrangements through MCOs.[8]

Medicaid, as designed by Congress, is critical to improving the health and wellbeing of women and families with low incomes across Oklahoma and the rest of the nation. Medicaid coverage of family planning services and supplies helps women's health, lives, educational success, and economic empowerment. It is critical then that SoonerCare is redesigned in a way that increases access to sexual and reproductive health care (SRH) and strengthens SRH services that are offered for Oklahoma women and all the SoonerCare enrollees that Planned Parenthood serves. It is also equally critical that any program design change is effective in addressing racial disparities, given the disproportionate rate women of color are enrolled in the Medicaid

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[2] *Fact Sheet: SoonerCare Fast Facts,* Oklahoma Health Care Authority, (2020), available at http://www.okhca.org/research.aspx?id=87.

[3] *Medicaid Enrollment by Gender,* Kaiser Family Foundation, available at https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Ranji, Usha, *Medicaid and Family Planning: Background and Implications of the ACA*, Kaiser Family Foundation (Feb. 3, 2016), available at https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/.

[5] Adam Sonfield et al., *Public funding for family planning, sterilization and abortion services, FY 1980–2006,* Occasional Report, New York: Guttmacher Institute, 2008, No. 38. (Jan. 2008), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/2008/01/28/or38.pdf.

[6] *Births Financed by Medicaid*, Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health,* Guttmacher Institute (Mar. 9, 2017), available at https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.

[8] Caroline Rosenzweig et al., *Medicaid Managed Care and the Provision of Family Planning Services,* Kaiser Family Foundation (Apr. 27, 2017), available at https://www.kff.org/womens-health-policy/report/medicaid-managed-care-and-the-provision-of-family-planning-services/.

population in addition to the significant racial disparities in poor health outcomes (including death) the COVID-19 pandemic has exposed.[9]

We applaud OHCA for seeking stakeholder input regarding SoonerCare's program design change. Given the outsized importance of Medicaid coverage for women, including women of color, as well as the proportion of Medicaid patients we serve, Planned Parenthood submit comments in the following sections: (1) benefits provided through managed care organizations (MCOs), (2) quality and accountability, (3) enrollee services, (4) provider payments and services, (5) network adequacy, (6) workforce development, and (7) administrative requirements. We have included a myriad of recommendations, utilizing a variety of approaches (such as increasing the scope of benefits and suggesting specific quality measures to ensure provision of quality SRH) that will increase access to SRH and strengthen SRH services for all SoonerCare enrollees.

We strongly urge OHCA to implement these recommendations when finalizing SoonerCare's RFP. Doing so is the first step in ensuring that Oklahoma women and SoonerCare enrollees are able to access essential services and have a better foundation in attaining overall wellbeing, educational success, and economic empowerment. Please continue reading below for our full comments.

I. OHCA should ensure that MCOs are expanding the scope of benefits provided to SoonerCare enrollees and guaranteeing timely access to family planning services.

a. OHCA should ensure that MCOs are diligently upholding the longstanding freedom of choice provision for family planning services, which guarantees timely and increased access to essential family planning care.

Federal law ensures that SoonerCare enrollees can receive medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services . . . who undertakes to provide . . . such services."[10] Importantly, the Medicaid Act guarantees special protection for freedom of choice of provider in connection with family planning services, explicitly ensuring that patients enrolled in managed care plans can continue to access family planning services from their provider of their choice.[11]

[9] Senator Debbie Stabenow and Senator Chuck Schumer, *Racial Disparities on Full Display: COVID-19 Is Disproportionately Affecting Communities of Color*, Democratic Policy & Communications Committee (Apr. 30, 2020), available at https://www.stabenow.senate.gov/imo/media/doc/DPCC%20Report%20on%20Racial%20Disparities.pdf.

[10] 42 U.S.C. § 1396a(a)(23).

[11] 42 U.S.C. § 1396a(a)(23)(B).

The freedom of choice provision has long been upheld as the cornerstone for family planning access. For example, the George W. Bush administration, in implementing the federal statute regarding Medicaid benchmark plans, recognized that family planning services are intimate in nature and that individuals' abilities to obtain family planning care from any qualified provider of their choice is essential for timely access to critical care. The Bush administration held firm that Medicaid enrollees—even those enrolled in benchmark plans—must be afforded free choice of provider for family planning services.[12]

OHCA should ensure MCOs are going above and beyond to uphold this provision and guarantee SoonerCare enrollees have timely access to family planning providers of their choice.

b. OHCA should ensure MCOs eliminate onerous prior authorization requirements, especially with regards to contraceptive care.

OHCA should ensure that MCOs are eliminating onerous prior authorization requirements so that SoonerCare enrollees can access care easily and quickly. Prior authorization does not serve a useful purpose within the context of family planning, as it is intended to be a cost-saving practice that ensures health issuers pay for medically necessary care. It is well-documented that family planning services already are cost-effective and result in future savings. American taxpayers save more than seven dollars for every dollar spent on publicly funded contraception,[13] and in 2010, the availability of publicly-funded contraception resulted in net public savings of $10.5 billion.[14] Greater access family planning services, including all twenty approved Food and Drug Administration (FDA) contraceptive methods,[15] would help further reduce costs associated with unintended pregnancy such as pregnancy complications and low birth weight infants.

c. OHCA should ensure MCOs eliminate contraceptive dispensing limits.

Twelve-month dispensing of oral contraception has been shown to be both beneficial for patient adherence and cost effective.[16] Yet evidence suggests that MCOs limit the initial supply

[12] 73 FR 73694, 73713-73714 (Dec. 3, 2008).

[13] Jennifer J. Frost et al., Guttmacher Inst., *Return on investment: A fuller assessment of the benefits and cost savings of the US publicly funded family planning program* (Oct. 2014), available at http://www.guttmacher.org/pubs/journals/MQ-Frost_1468-0009.12080.pdf.

[14] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2010*. (Jul. 2013), available at http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf.

[15] *Birth Control Guide*, FDA, available at https://www.fda.gov/media/135111/download.

[16] *Access to Contraception*, American College of Obstetricians and Gynecologists, available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception.

or refills of contraception prescribed to patients.[17] One survey of plans found that most plans covered one or three months of oral contraceptives at one time.[18] MCOs may deny coverage for yearlong contraception because of concerns that patents will not stay enrolled for the entire year, or because some patients may discontinue use before the year is complete.[19] To ensure coverage, OHCA should require MCO contracts to include provisions that require plans to cover year long dispensing with certain exceptions.[20]

d. OHCA should require MCOs to include community-based providers in social determinants of health programs. To measure the effectiveness of referrals to community-based organizations, OHCA should consider implementing a unified referral platform.

Safety net and community-based providers (such as Planned Parenthood) care for vulnerable and underserved populations, who are often in need of housing assistance, food security, education and employment assistance. As such, community-based providers have a critical role to play in connecting SoonerCare enrollees to these services. OHCA should consider requiring MCOs to include providers, such as Planned Parenthood and other community-based providers, in programs that directly address social determinants of health and provide adequate reimbursement to these providers for connecting SoonerCare individuals to the necessary supports.

Once referrals are made, OHCA should also measure MCO performance on the effectiveness of these referrals. OHCA may also consider, like North Carolina, implementing a referral platform to address the needs of SoonerCare enrollees.[21] A standardized, statewide screening tool and unified platform would ensure that referrals to CBOs are actually given and are given to the correct providers. If such a platform is implemented, OHCA should ensure that MCOs provide the necessary information to maintain a robust statewide resource directory, with additional enrollee touchpoints (such as a call center, navigators, etc.) that will further drive accountability around services that are delivered.

e. OHCA should bolster access to transportation for SoonerCare enrollees. Doing so will ensure that underserved populations, including women with low incomes, are able to get to and from their appointments and receive the care they need.

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[17] Zolna et al., "Insurance-related Practices at Title X-funded Family Planning," *Women's Health Issues* (Nov. 3, 2017), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5939377/.

[18] *Id.* at Medicaid Managed Care and the Provision of Family Planning Services.

[19] Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States, Manatt Health (May 2019), available at https://www.manatt.com/getattachment/4dfc897e-6f05-42dd-b82b-a0bbc8725c52/attachment.aspx.

[20] *Id.*

[21] NCCARE360, North Carolina Department of Health and Human Services, available at https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360.

While Planned Parenthood does not recommend a specific approach in improving access to transportation for SoonerCare enrollees, we want to underscore that access to transportation is vital to making sure SoonerCare enrollees receive the care they need. As such, Planned Parenthood encourages OHCA to require that MCOs structure their managed care plans to meet the requirements for network sufficiency and solvency when providing the transportation benefit. In addition, we also encourage OHCA to require MCOs to report issues that SoonerCare enrollees face, such as delays in transportation and poor customer service, to gain a better understanding of the issues and scope of transportation problems affecting access to care. With such data, OHCA can further require MCOs to design a SoonerRide system that better meets the needs of the community.

It is also important to note that transportation barriers can affect women's access to health care services. These barriers may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Many women with low incomes do not have access to affordable transportation to get to and from medical appointments.[22] For them, transportation issues can be a major barrier to needed health care, including receiving services such as postpartum contraception, pregnancy tests, Pap smears, and tests for sexually transmitted infections. Transportation is interrelated with other social determinants of health such as poverty, social isolation, access to education and racial discrimination.

II. OHCA should pursue MCO contracts that ensure and improve quality of SRH available to Medicaid enrollees through value-based payment arrangements that incentivize reporting on quality measures.

Quality measures are a critical element in transforming the health care system from the fee-for-service (FFS) model to the value-based payment (VBP) model. They are vital tools that help MCOs measure or quantify health outcomes, patient perceptions, and health care systems' ability to provide high-quality health care.[23] Payment incentives are also used to identify and solve for weaknesses in the health care system, and can drive data collection and reporting on existing measures. Planned Parenthood urges OHCA to pursue MCO contracts that ensure and improve the quality of SRH available to SoonerCare enrollees.

Although Planned Parenthood does not endorse any specific payment model, OHCA should consider a variety of VBP arrangements in their managed care contracts with MCOs that could

[22] Silver, D., et al., *Transportation to clinic: findings from a pilot clinic-based survey of low-income suburbanites*, Journal of Immigrant and Minority Health [2012 Apr;14(2):350-5], available at https://www.maine.gov/dhhs/oms/nemt/nemt_index.html (finding that 25 percent of patients missed an appointment due to transportation problems).

[23] *Quality Measures*, Centers for Medicare and Medicaid Services (Feb. 11, 2020), available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures#:~:text=Quality%20measures%20are%20tools%20that,quality%20goals%20for%20health%20care.

incentivize providers to track and report accurate and complete information about the quality and utilization of family planning services. This could include paying providers for reporting quality performance on designated measures (pay-for-reporting) or for achieving certain performance levels on those measures (pay-for-performance).[24]

Depending on the quality metric, it could be advantageous to incentivize MCOs to report on specific quality measures. For example, the Office of Population Affairs (OPA) developed contraceptive care measures, endorsed by the National Quality Forum (NQF) that assess the provision of most-to moderately-effective forms of contraception to all women of reproductive age.[25] Notably, the contraceptive care quality measures are unique among quality measures in that they assess preference-based decisions that women make with respect to pregnancy prevention. Unfortunately, because of the history of reproductive coercion in the US,[26] utilizing other VBP arrangements like pay-for-performance or population-based payment models could inadvertently incentivize providers to coerce certain women into using contraception or specific types of contraception.[27] Instead, pay-for-reporting incentives reward data collection on contraception use.[28] OHCA can use the data gathered through a pay-for-reporting arrangement to map rates of contraceptive use and to identify geographic areas or provider practices with low rates of contraception that may merit further investigation to identify systematic barriers to access.[29]

Planned Parenthood encourages OHCA to include family planning and sexual and reproductive health priorities and quality initiatives in MCOs contracts.[30] Yet, evidence suggests that several Medicaid managed care plans across the country are not collecting data on family planning quality beyond the contraceptive quality measures recently endorsed by the National Quality Forum.[31] MCO contracts may be written to require SoonerCare managed care plans to evaluate data and propose quality initiatives to address health gaps or disparities in access to SRH, including contraception, STI/HIV services, preventative cancer screenings, well visits, and other services. States such as North Carolina and Illinois have set similar priorities for MCOs. Again, as noted above, OHCA should take care to design quality initiatives in a manner that preserves

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[24] *Measuring Quality Contraceptive Care in a Value-Based Payment System,* Planned Parenthood & Manatt Health (Oct. 7, 2019), available at https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-publishes-new-guidelines-to-help-states-effectively-implement-contraceptive-care-quality-measures.

[25] *Performance Measures*, Office of Population Affairs (Oct. 24, 2019), available at https://www.hhs.gov/opa/performance-measures/index.html.

[26] Elizabeth Raterman, *Tracing the History of Forced Sterilization within the US* (Mar. 29, 2019), available at http://www.healthlawpolicy.org/tracing-the-history-of-forced-sterilization-within-the-united-states/

[27] *Measuring Quality Contraceptive Care in a Value-Based Payment System*, *supra*.

[28] Ibid.

[29] Ibid.

[30] *Id.* at Enhancing Access of Family Planning Services.

[31] *Id.* at Medicaid Managed Care and the Provision of Family Planning Services.

patient choice with regards to methods of family planning because of the risk of reproductive coercion.

Finally, SoonerCare transformation should prioritize the effort to reduce health care disparities among women of reproductive age. This is particularly relevant during the COVId-19 pandemic, which has already been shown to disportionately affect communities of color, in particular Black people.[32] Non-white women are more likely to experience reproductive health care disparities, including higher rates of teen pregnancy, maternal and infant mortality, and low birth weight infants.[33] Considering the strong roles of community-based approaches in achieving high health care impacts, the models should direct performance payments and shared savings to community-based providers who have capacity to address social determinants of health and reduce existing health care disparities, in particular reproductive health care disparities, in Oklahoma.

III. OHCA should ensure MCOs adequately reimburse community-based providers who provide care coordination.

Given the outsized role providers like Planned Parenthood play as a primary source of health care and care coordination, OHCA should require MCOs to provide adequate reimbursement for providers engaging in care coordination. Many community-based providers engage in care coordination to ensure that patients are receiving comprehensive and wraparound services that help them achieve their health goals and overall wellbeing. Moreover, providers like Planned Parenthood may often be the only source of care for many women with low incomes: data shows that many women rely on this care and it is their only recent source of health care.[34]

Care coordination in these settings goes beyond simple referrals or even "warm handoffs" to another provider. Community-based providers like Planned Parenthood continue to follow up with patients to ensure they are receiving the care they need on an ongoing basis. This work often goes unreimbursed, as it is not a defined fee-for-service health care service. Importantly, adequate reimbursement for wraparound care allows safety net providers to continue to offer this assistance to SoonerCare patients and improve health outcomes.

IV. OHCA should ensure that SoonerCare enrollee services are strengthened through evaluation with a variety of metrics, as well as utilizing telehealth to increase access to care, particularly contraceptive services.

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[32] *Id.* at Racial Disparities on Full Display.

[33] *North Carolina Resident Population Health Data by Race and Ethnicity*, North Carolina Health and Human Services (Nov. 2015), available at http://www.schs.state.nc.us/schs/pdf/NCPopHealthDatabyRaceEthNov2015.pdf

[34] *See* Frost J. et al., *Specialized Family Planning Clinics in the United States*, Womens Health Issues (2012;22(6):e519-e525), available at https://pubmed.ncbi.nlm.nih.gov/23122212/ (finding that 41% of respondents, or 4 in 10, relied on family planning clinics as their only recent source of health care).

a. MCOs should utilize a variety of metrics that evaluate SoonerCare enrollees' access to care, provider satisfaction, and other important considerations, such as safety and equity.

Successful management of SoonerCare requires periodic assessment of critical data to determine if and when policy changes are needed to ensure that SoonerCare enrollees are receiving the care they need. Planned Parenthood encourages OHCA to require MCOs to collect data using the following metrics: (1) patient satisfaction, (2) provider satisfaction, and (3) timeliness of care, including eliminating onerous prior authorization requirements and referrals to access SRH. In addition to the aforementioned metrics, MCOs can also demonstrate that enrollee services are being adequately administered through reporting of the provision of combined testing of chlamydia and gonorrhea, life-saving cancer screenings, and contraceptives. Finally, Planned Parenthood encourages OHCA to also utilize the following measures with respect to enrollees and providers: risk reduction, safety, efficiency in administering services, equity issues that are addressed, and value that is being delivered through care.

b. MCOs should expand the covered telehealth modalities to reduce barriers to accessing care, in particular contraceptive services, for women of color.

Telehealth can be effective for cost reduction within the broader health care system, by allowing patients to avoid more costly care settings, like emergency care.[35] It can also be a vital tool in eliminating health care access barriers by allowing patients who live in provider shortage regions, like rural or medically underserved areas, to seek care virtually.[36] Unfortunately, coverage limitations on the types of telehealth modalities used by patients, or requirements for encryption on these modalities, serve as a significant barrier to accessing telehealth services, particularly for women of color,[37] people with low incomes,[38] immigrants[39] and older adults.[40]

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[35] See Garrison Nord et al., *On-Demand Synchronous Audio Video Telemedicine Visits are Cost Effective*, 37 Amer. J. of Emergency Medicine 890, 890-894 (Aug. 7, 2018), available at https://www.ajemjournal.com/article/S0735-6757(18)30653-3/fulltext.

[36] *How Telemedicine Can Help the Physician Shortage,* InTouch Health (2019), available at https://intouchhealth.com/telehealth-a-solution-to-managing-scarce-physician-resources/.

[37] Daniel Walker et al., *Exploring the Digital Divide: Age and Race Disparities in Use of an Inpatient Portal, 26* Telemedicine and e-Health 603, 603-613.(May 6, 2020), available at https://www.liebertpub.com/doi/10.1089/tmj.2019.0065.

[38] David Velasquez & Ateev Mehrotra, *Ensuring The Growth Of Telehealth During COVID-19 Does Not Exacerbate Disparities In Care*, Health Affairs (May 8, 2020), available at https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/.

[39] Whitney L. Duncan & Sarah B. Horton, *Serious Challenges And Potential Solutions For Immigrant Health During COVID-19,* Health Affairs (Apr. 18, 2020), available at https://www.healthaffairs.org/do/10.1377/hblog20200416.887086/full/.

[40] Eric Wicklund, *Surveys Suggest Seniors Aren't Using Telehealth During COVID-19 Crisis,* mHealth Intelligence (Ma 27, 2020), available at

Often, these communities lack high speed internet or telehealth equipment (such as laptops or tablets) that is necessary to have a successful live two-way video telehealth. In fact, the Federal Communications Commission (FCC) estimates that 14 million Americans still lack access to fixed broadband service at threshold speeds.[41] In rural areas, nearly one-fourth of the population (14.5 million) lack access to this service.[42] Additionally, studies have shown that Black and Latinx patients are more likely than white patients to access their health data through smartphones instead of tablets or laptops.[43] Ensuring telehealth coverage includes two-way audio communications allows SoonerCare enrollees who do not have access to expensive electronic equipment—such as computers, smartphones or high-speed internet—to correspond with their health care provider in a timely manner.

Reducing barriers to telehealth utilization, like expanding the covered telehealth modalities, among SoonerCare enrollees during the public health emergency and beyond will improve equitable access to quality SRH. STD/STI rates are increasing and continue to disparately impact people of color and LGBTQ people.[44] Additionally, although unintended pregnancy rates are falling, communities of color and people with low incomes continue to face disproportionately high rates and limited access to contraception.[45] The COVID-19 pandemic has only exacerbated these disparities by creating additional barriers to care, such as provider shortages, limited in-person service hours, stringent social distancing, and economic instability for patients.[46] In fact, a survey conducted by the National Coalition for STD Directors found that 66 percent of STI

https://mhealthintelligence.com/news/surveys-suggest-seniors-arent-using-telehealth-during-covid-19-crisis.

[41] See *2019 Broadband Development Report,* Federal Communications Commission (May 2019), available at https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2019-broadband-deployment-report; see also Tyler Sonnemaker, *The Number of Americans without Reliable Internet Access May be Way Higher than the Government's Estimate — and that Could Cause Major Problems in 2020,* Business Insider (Mar. 24, 2020), available at https://www.businessinsider.com/americans-lack-of-internet-access-likely-underestimated-by-government-2020-3.

[42] Ibid.

[43] Eva Chang et al., *Racial/Ethnic Variation in Devices Used to Access Patient Portals, 24* Amer. J. of Managed Care *1, 1-8* (Jan. 18, 2018), available at https://pubmed.ncbi.nlm.nih.gov/29350513/#:~:text=Conclusions%3A%20Although%20racial%2Fethnic%20minority,did%20non%2DHispanic%20white%20users.; see also Sheba George et al., *How Do Low-Income Urban African Americans and Latinos Feel about Telemedicine? A Diffusion of Innovation Analysis,* International J. of Telemedicine and Applications (Sep. 2012), available at https://www.researchgate.net/publication/230895878_How_Do_Low-Income_Urban_African_Americans_and_Latinos_Feel_about_Telemedicine_A_Diffusion_of_Innovation_Analysis.

[44] *CDC Fact Sheet: Reported STDs in the United States, 2018,* Centers for Disease Control & Prevention (Oct. 2019), available at https://www.cdc.gov/media/releases/2017/p0926-std-prevention.html.

[45] *Unintended Pregnancy in the United States,* Guttmacher Institute (Jan. 2019), available at https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[46] Laura Lindberg et al., *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences,* Guttmacher institute (Jun. 2020), available at https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health; Hilary Brueck, *STD Rates Appear to be Quietly Skyrocketing across the US, as Fewer People Get Tested and Treated during the Pandemic*, Business Insider (May 18, 2020), available at https://www.cdc.gov/std/stats18/minorities.htm; see also *Health Equity Considerations and Racial and Ethnic Minority Groups,* Centers for Disease Control & Prevention (last updated Jul. 24, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

clinics reported a decrease in sexual health screenings and testings.[47] These new infections are concentrated among LGBTQ people[48] and people of color,[49] which contributes to the existing health inequities in reproductive care. Further, a study conducted by Guttmacher Institute found that 33 percent of women reported that because of the pandemic they had had to delay or cancel visiting a health care provider for reproductive care, or experienced difficulty refilling their birth control prescriptions.[50]

V. OHCA should require MCOs to provide adequate reimbursement for Medicaid providers like Planned Parenthood. Such a requirement will help guarantee SoonerCare enrollees' access to necessary care.

As OHCA knows, Oklahoma's reimbursement rates for family planning services impact (1) providers' willingness to accept SoonerCare enrollees, thus directly affecting their access to care, and (2) the long-term viability of safety net health centers that are particularly depending on Medicaid revenue. OHCA should ensure that MCOs provide adequate reimbursement for family planning services and supplies such that SoonerCare enrollees are able to access the care they need from providers of their choice and Oklahoma's Medicaid provider network is further stabilized.

First, OHCA should contract with MCOs that carefully select payment approaches to increase reimbursement to safety net providers like Planned Parenthood, which face low reimbursement and bundled payment issues.[51] MCO contracts could establish a payment floor that is no less than the reimbursement rates offered in the state's fee-for-service SoonerCare program, or tie payment to some percentage of a public payer's rates (e.g., 150 percent of Medicare).[52] Furthermore, in order to address bundled payment issues that many health centers face, MCO contracts should mandate that MCOs must pay separately for family planning services provided in the same visit. For instance, MCOs should pay separately for contraceptive counseling and same-visit insertion of long-acting reversible contraception (LARC).

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[47] *COVID-19 and the State of the STI Field*, National Coalition of STD Directors (2020), available at https://www.ncsddc.org/wp-content/uploads/2020/05/STD-Field.Survey-Report.Final_.5.13.20.pdf

[48] Hilary Brueck, *supra.*

[49] *STDs in Racial and Ethnic Minorities,* Centers for Disease Control & Prevention (last updated Jul. 2019), available at https://www.cdc.gov/std/stats18/minorities.htm.

[50] Laura Lindberg et al., *supra.*

[51] Bundled payment methodologies without accounting for the specific services provided may unintentionally incentivize providers to deliver services across more than one visit. Such a practice is a barrier for SoonerCare enrollees accessing multiple services quickly, such as same-visit access to contraception.

[52] *Id*. at Enhancing Access to Family Planning Services in Medicaid.

Second, the other side of ensuring adequate reimbursement rates is to ensure providers are receiving payment for their services in a timely fashion. OHCA should ensure MCOs are paying claims within 15 days of electronically filed claims and paying claims within 30 days of filing at the minimum.

VI. OHCA should set strong network adequacy standards and contract with MCOs that offer adequate provider reimbursement to support workforce development. Both initiatives will ensure SoonerCare enrollees can access essential family planning services in a timely manner.

a. OHCA should set strong network adequacy standards to ensure that SoonerCare enrollees, particularly those who live in underserved and rural and urban communities, are able to access care.

As OHCA works to develop its own and mirror federal network adequacy standards, it is important to ensure that MCO networks consider a wide variety of factors, such as added need for telehealth/telemedicine, wait times, and restricted appointment availability due to COVID-19 (in addition to existing considerations around telehealth/telemedicine, wait times and appointment availability), enrollee-to-provider ratios, and time and distance requirements. Sufficient number, mix, and geographic distribution of included providers is necessary, including essential family planning providers.

OHCA should ensure that strong standards are set to guarantee that MCOs cannot avoid enrolling people who live in underserved rural and urban communities with low incomes to cut costs. In addition, OHCA should also require that the providers available to SoonerCare enrollees are able to meet their diverse needs. To mirror and go beyond federal standards for quality health plan, MCO networks must:

- Include a broad range of essential community providers (ECPs), including safety net providers who are open to all, offer sliding scale services, and/or offer enhanced services like outreach and translation;
- Set and meet sufficient time and distance and timeliness of care requirements;
- Maintain sufficient number and types of providers, including for mental health and SUD, to ensure access to services without reasonable delay;
- Meet transparency and directory/network adequacy template requirements to ensure that information is accessible to and understandable by enrollees; and
- Comply with federal nondiscrimination protections.

Finally, Planned Parenthood underscores that time is of the essence when accessing family planning services and supplies. Being unable to access care can result in not only missed

appointments, but unintended pregnancies and undiagnosed STIs and life-threatening cancers. As such, OHCA should ensure to set network adequacy standards that guarantee timely access to critical care.

b. OHCA should contract with MCOs that offer adequate reimbursement rates to support workforce development.

MCOs can support the provider workforce in a number of ways, but most importantly through adequate reimbursement. Safety net providers who see mostly SoonerCare enrollees struggle to recruit and keep high quality clinicians and nurses, in large part due to low reimbursement rates. MCOs should offer higher reimbursement rates than traditional SoonerCare. The state could also enhance reimbursement for health centers that train clinicians and support staff in-house, to maintain a steady flow of provider trainees coming into these settings.

It is important to note that SRH providers provide primary and preventive care to their patients, and this care is vital to patients' health and wellbeing. As such, they should be explicitly included in MCO network adequacy requirements and in all provider workforce development programs.

VII. OHCA should ensure MCOs streamline data sharing while protecting patient privacy and security through full implementation of the interoperability rules, as well as providing subsidized access to technology.

a. OHCA should fully implement the interoperability rules and ensure protection of patient information to streamline data sharing.

Data sharing is vital for care coordination and patient-centered care, but it carries serious confidentiality and data security risks when extended too far. The federal government recently finalized its rules to enhance interoperability between data systems, but they do leave patient data at risk by requiring providers and payers to hand over patient data to apps that are not regulated by HIPAA.[53]

Patients have a right, under these federal rules, to access their own health data, allowing them to bring their records to new providers and payers and to have all the information they need to make health care decisions. OHCA should ensure that MCOs and providers fully implement the interoperability rules in order to streamline data sharing, and give SoonerCare enrollees

[53] 42 C.F.R. §§ 406-407 (May 1, 2020), available at https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and; 45 C.F.R. §§ 170-171 (May 1, 2020), available at https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification.

information regarding their rights to their health information so that they can access their information when they need it. In addition, primary care providers should have access to patients' specialist or hospital records (except where those must be kept confidential) to facilitate care coordination.

OHCA must also protect patient information from data mining and selling by third party vendors not governed by HIPAA and other privacy rules. At the very least, MCOs and providers must inform patients of the risks they bear in sharing their health records with unaffiliated apps or programs. OHCA should, if possible, limit the uses to which these programs may put patient data, so they are prevented from hurting SoonerCare enrollees through unethical practices.

b. *OHCA should provide subsidized access to technology to incentivize compliance with the interoperability rules.*

The push for interoperability at the federal level will help providers and MCOs to coordinate their records and share information seamlessly. However, the full implementation of these rules relies upon provider and insurer access to the most up to date technology, which may be expensive for providers with limited resources who do not already use up to date electronic health records (EHRs) and similar technology. OHCA could offer subsidized access to technology that meets federal standards of interoperability, or grants for providers who see a majority SoonerCare enrollee population. By making technology more affordable, OHCA can improve care coordination and align both providers and MCOs.

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Planned Parenthood appreciates the opportunity to comment on the request for public feedback for finalizing the SoonerCare Comprehensive Managed Care Program RFP. When finalizing the RFP, we encourage OHCA to implement the recommendations and approaches to ensure that in the next iteration of SoonerCare, access to sexual and reproductive health care is increased and SRH services are bolstered for SoonerCare enrollees. Accessing such care is critical at all times, but especially relevant during the COVID-19 pandemic, when access to reproductive health services has been decreased and racial disparities have been exacerbated.

If you require additional information about the issues raised in this letter, please contact Tamya Cox-Toure, 405-724-3996, tamya.cox-toure@ppgreatplains.org.

Respectfully submitted,

Brandon J. Hill, PhD

President and Chief Executive Officer
Planned Parenthood Great Plains
Planned Parenthood of Arkansas and Eastern Oklahoma

Oklahoma Medicaid Change to Managed Care (Health Plan) and Carved out Dental Managed Care.

See our Provider Stakeholder Reponses to state questions in BLUE.

Questions for Stakeholder Input: Quality and Accountability

1. What mechanisms should the state use to incentivize MCOs to improve member outcomes?
    - OK should incentive MCOs by renewing their contract, not by offering additional incentives. Any incentive paid to the MCO should be also distributed to the healthcare providers who are doing the work improving member outcomes. (Value Based Programs)
    - If metrics are used, the utilization of care should be the number one item in which MCOs are held accountable.
2. What are the most important indicators of MCO performance? Why?
    - Utilization rates for care to Medicaid enrollees.
        - Often times Network Adequacy is used and provider enrollment is the key metric. The problem with this metric is that it only looks at provider network enrollment, and not how many Medicaid enrollees are receiving care. (I.e., a provider might be in the "Medicaid Network," but only sees a few Medicaid patients a month.
        - We found that in another state, there were 1,977 dental providers who were enrolled with Medicaid. Of those, 490 saw less than one Medicaid patient per month, 1,467 providers saw less than one Medicaid patient per day, and only 122 saw more than five patient per day.
3. What measures of health outcomes should be tracked?
    - For Dental
        - Are patients receiving preventative care?
        - Is the reimbursement of restorative care going up or down?
        - Are ER visits from dental increasing or decreasing?
            - This might be hard to track with Dental being carved out of the MCO Health Plan.
    - For Vision Care
        - Number of Comprehensive Eye Exams (utilization of comprehensive eye exam code)

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
    - Transparency with data between provider and MCO regarding member utilization status (I.e., Gaps in Care lists share with the provider for additional outreach to keep member in compliance with regular routine/preventative care)
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
    - The state should require consistency across all MCOs.
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

    - MCOs need to work with the specific agencies who care for these individuals and assist them in having the correct paperwork and health history for healthcare visits.
    - Additional support for providers who are willing to take on organizational partners, such as, foster care agencies, to assure children can receive care.

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
    - Utilization of services
    - Access to Care
    - Timely solving of grievances
    - Ease of applying for benefits/application assistance

- How can MCOs best serve individuals who primarily speak a non-English language?
    - Reimburse providers for translation services, especially in-person sign language interpreters.

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
    - Credentialing timeframe
    - Payment timeframe
    - Response time to provider communications
    - Proof of willingness to partner with providers for the benefit of the members

- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?
    - MCOs should be required to reimburse at the state Medicaid rate, at a minimum (Especially for those who are grandfathered in. It's unfair to pull rates from those who agreed to previous contracted rates)
    - The cost savings to the state should be in the form of better health outcomes for its members, not via reduced rates to providers.
    - MCOs should be required to share with the state the fees that are being offered to the provider (this data should be public knowledge).
        - This should include any contract that the MCO has with a Third Party Administrator (even as a private contract) if the TPA will be affecting provider reimbursements.

- What is appropriate for timely payment of claims?
    - Within 5 business days of a clean, electronic claim
- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?
    - Providers should have a mechanism to speak to both the state and the MCO when problems arise. Our experience is that MCOs place blame on the state for administrative errors. Since there are no direct contacts for providers at the state level, providers are left with no recourse to poor management from the MCO.
- How can MCOs best communicate to providers about updates and changes to plan policies?
    - Active and Involved Provider rep from the MCO with a contact at the provider
    - Email and/or regular mail.
    - Updating websites without notice is not sufficient for providers as they are not looking at the MCO's website daily to determine if the rules have changed.
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers?
    - MCOs should be required to reimburse providers for administrative errors caused by the MCO. We have seen one dental payor cost our supported practices over $300,000 in additional administrative costs because their computer system was not able to adequately process claims.
    - We have also seen inappropriate denials due to MCO errors and the provider must expend additional costs to resubmit claims.
    - If a provider must resubmit a claim due to and MCO error, they should be reimbursed for the additional time/resources.
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?
    - Open and clear measures and clear guidance around these measures. Do not deviate from that guidance unless proper notice has been given.

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?
    - Provide appropriate reimbursement to assure a strong network available for services.
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?
    - By offering fair reimbursements
    - By reducing administrative burdens
    - By reducing the amount of improper denials
    - By being a PARTNER with the provider in care delivery
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?
    - Create boards that are made up of beneficiaries, providers, MCO representatives, as well as OHCA representatives.

    - The provider representatives should be from offices that primarily treat Medicaid recipients.

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?
    - There needs to be a mechanism for the state and MCOs to receive feedback from providers.
    - Opportunity for meetings between reps from Provider, State and MCO all included
        - If the MCO takes on a Third Party Administrator, the TPA should also be held accountable for these same meetings.
- How can the state and MCOs use appeals data to improve utilization management and access?

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?
    - Partnership in continuity of care lists such as Gaps in Care for services offered through a member's benefits. (6 month dental recall, annual physical, annual vision exam, etc.)
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?
    - Computerized metrics that are reviewed by professionals with the same licensure (I.e., Dentists reviewing dental metrics not medical doctors and vice versa).
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace?
    - Yes.

ADDITIONAL COMMENTS:

- It would be great to have a committee created, that included providers in the field, to look at the options for the Managed Care Organizations before a decision is made.
- Third Party contracts should NOT be held as private contracts that the state doesn't have access to or say in how their providers are treated.

Re: 80720200002

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care? Since the last RFI to transition ABD into it's own MCO a number of years ago failed to materialize, history suggests that MCOs are not good for Oklahoma.
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups? This could lead to inequities.
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? Primary care establishments are already encouraging this as well as the health insurance companies. Incentivizing has proven to be the most effective manner.

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? Extended hours. How could managed care plans help individuals resolve problems with accessing care? Accept any willing provider.
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing? EHRs and HIEs(MyHealth Access Network)
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? MyHealth Access Network can track this through a text app. How could OHCA measure MCO performance on social risk factor mitigation strategies? MyHealth Access Network
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment? MyHealth Access Network
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction? Annual Comprehensive Eye Exams can determine early signs of other diseases.
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? Many counties have transit services.

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?
- What are the most important indicators of MCO performance? Why?
- What measures of health outcomes should be tracked?

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
- How can MCOs improve the management and coordination for members with chronic or complex health conditions?
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology?
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs?
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service?
- How can MCOs communicate with members and receive regular input and feedback on program improvements?
- What tools and resources would help members search for providers? What information should be provided?

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services?
- Should OHCA require MCOs to maintain a minimum level of reimbursement? Yes such as Medicare allowed amounts. How should this be accomplished? How should the state sustain provider compensation? Reduce the amount paid to the MCO
- What is appropriate for timely payment of claims? 2 weeks like Medicare when sent electronically
- What provider services functions or processes should be standardized across MCOs? Health Information Exchange required. How should this be accomplished? Provider contracts should include the requirement for participation. What are the barriers to standardizing the function and how should these be addressed? Statewide access to reliable internet.
- How can MCOs best communicate to providers about updates and changes to plan policies? Postal service, email notices and website support.
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Training, training, training! In person,

online, web based and at times convenient for attendance. Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers? Contracting updates.

- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?
- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?

Questions for Stakeholder Input: Network Adequacy

- How should MCOs work with providers to ensure timely access to care standards are met?
- What are reasonable time and distance standards in Oklahoma by provider type? Less than 100 miles for all types.
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? Reimburse and incentivize at reasonable rates (such as Medicare)
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers?

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Text surveys Are there proactive approaches that should be explored? Members should receive a follow-up survey in order to report any issues, concerns or good experiences.
- How can the state and MCOs use appeals data to improve utilization management and access? If members are reporting negative experiences with a provider, the provider should be informed and trained.

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? MyHealth Access Network. What data should be shared between MCOs and providers to facilitate patient care? All information approved under HIPAA and state standards.
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? Statewide reliable internet
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed? Track encounters that are occurring in multiple clinics for the same CPT and ICD-10-CM.
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? Since this is happening in the current environment, it should continue to be a choice.

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care? Majority of response were to make the MCOs prove that they can handle the populations that they are given in phase one and use this approach for each phase of the implementation of new populations-want to see community engagement (HANs)-MCOs believe you should put everyone in at once or at least allow the excluded populations the opportunity to opt in to the MCOs
- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups? Yes, require the MCOs to cover all populations---Engage stakeholders to determine---Specialty plans—want to carve out specialty plans
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? Make compliance a condition of enrollment, transportation options, telehealth accessibility and reimbursement—Incentives for keeping appointments-annual checkups---No ER visits or IP in a year-quit smoking—weight management---Collaborative state/MCO approach, -Community Based Organizations, Incentives, F2F engagement activities, Provider partnering—incentives and technology-interactive apps, text messaging—Data Analytics---in home service options Care managers and Pharmacist—Philosophy of engagement—Incentive payments to providers---Consider ACOs compensated thru shared savings

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care? Transportation options, telehealth accessibility and reimbursement for telehealth services-Same day appointments -- A streamlined and efficient workflow that allows easy communication and data transfer with the providers. Scheduling tools should be made available for the MCO's for easy same day appointment scheduling options, and a connected portal for data sharing with the providers to view the notes and make suggestions through the portal. Monitor provider access-reduce amount of administrative requirements for providers to enter their networks, MCOs should be required to re-invest dollars into community—Health literacy is an issue MCOs should be required to learn about their members and the communities that they serve-Social determinate of health must be considered throughout the lifespan. Building community networks. Whole person care programs need to be required and incentivized
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing? Partnerships between medical and behavioral health facilities that do not have integrated services Case management—HIE—Bundle MAR services together for authorization and payment
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? By closing the loop on these types of referrals, similar to how we have to do this when referring

patients to specialty care—we must be able to provide documentation that the referral occurred and the outcome. Existing case management—HIE—ability to track referrals to social groups in detail not just we sent a report and it was received-referral tracking tool such as the one used by HANs currently. Should incentivize specialty providers to participate in referral tracking system. How could OHCA measure MCO performance on social risk factor mitigation strategies?

- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment? By utilizing community health centers that already have this in place. Our CHC has every bit of this in place. Require screening tools to be used contract with local OP facilities to offer treatment and therapy—Contract with OPHIC who has a proven model for influencing changes in primary care—True community based BH-Should not have to travel across state for IP BH

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction? Case managers—Back to school programs, spring-cleaning, summer camps—Registered dietitians, diabetes educators, lifestyle coaching, home visits, in home therapy, caregiver support and services, CM training, member/caregiver training, transportation, healthy foods

- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? That works in the urban areas, but Uber and Lyft are not available in most rural areas. Maybe incentives for people to drive for these types of companies in rural areas. Ride sharing—Carve out NET- let SoonerRide become more innovative and adjust to members needs, rides for same day appointments, transportation for parent and all dependent children,

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes? Is there an ACO type model for MCOs?-monetize positive outcomes related to member improvement in stratified outcome measures for specific health care conditions---Data sharing sot members can see which MCO's perform the best—Partial withhold for MCOs PMPM, HealthySteps, HANs, and CHIO's should be required and incentivized—P4P should be set above the usual standard-should not be paying for standard care but exceptional care.
- What are the most important indicators of MCO performance? standards of PCMH, UDS, etc Why? everyone should be held to same standards Member engagement to build rapport and trust-Patient engagement—Improvements in CMS Quality measures—Improved member outcomes, stabilized and more predictable health care costs, increased quality and efficiency – Provider satisfaction
- What measures of health outcomes should be tracked? Number of contacts before member engagement. Progress of patient goals. ER visits—CMS Guidelines—HEDIS measures 30/60/90 day recidivism—member satisfaction, disparities in health and social outcomes at the state, county, zip code, and provider levels

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers? The MCO would need a reliable way to communicate the ongoing progress and needs of the members, such as an electronic communication interface—Utilization management tools to achieve and track outcomes—Data driven approach, predictive modeling---HIE
- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden? Consistent goals and communication techniques/platforms across the board. MCOs should require education to provider groups—HIE--
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs? Call in lines to reduce ER-better access to care no co-pays for PCMH visits for wellness and sick visits to reduce ER visits-telehealth—accessible and available provider network—home based BH
- How can MCOs improve the management and coordination for members with chronic or complex health conditions? Direct communication with providers-- better access to care no co-pays for PCMH visits for wellness and sick visits to reduce ER visits –Universal data base-Team approach with Care Coordinators working with those members
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations? Assign Care Managers with MCO or with PCPs office---Community health care partners—Comprehensive training – take advantage of established programs

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services? Surveys—Dr visits vs ER visits-increased case management engagement, increase PCP visits, medication compliance—Patient reported outcomes, NQFM NCQA, evidence based and standardized metrics
- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology? Provider translators in PCP office-establish language lines-Case managers that speak multiple languages, prepare materials in multiple languages, bi-lingual staff, culturally consciousness
- How can MCOs use technology (such as web-based applications and mobile phones) to help How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service? health apps, telehealth platforms, phone apps, videos, interactive prerecorded videos through app, map based resource finder, quick health tips in the app, texting, HIE, MCOs should consider providing devices
- How can MCOs communicate with members and receive regular input and feedback on program improvements? Phone, home visits, health fairs, tv advertisement, mobile health services, surveys- MCOs should consider providing devices
- What tools and resources would help members search for providers? What information should be provided? Phone, chat platform, portal, general info about services near the member, Apps—website with participating provider and overview of services offered along with links to provider website

Questions for Stakeholder Input: Provider Payments and Services

- What metrics should be used to measure MCO performance with regards to provider services? Provider feedback, KPI measures-increased PCP visits, reduced no-shows, increased compliance, increased screening and immunization rates, increased patient engagement, reduce non-emergent ER and IP visits---CMS, eCQM's, UDS, HEDIS—incentivize meeting beyond standard utilizing existing programs
- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation? Minimum of OHCA current levels—Value Based small PMPM with majority of payment in quality improvements—Publish rates online for transparency
- What is appropriate for timely payment of claims? Same as today-Monthly by the 15th—30-45 days
- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? Maintain current compensation--- What are the barriers to standardizing the function and how should these be addressed? MCO cost sharing-Quality measures, panel size, payment methodology, provider and patient portals
- How can MCOs best communicate to providers about updates and changes to plan policies? Monthly or bi-monthly meetings with providers—Email, newsletters, alerts on portal-online video/playbacks available
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers? Initial training, customer service helpdesk, FAQs on the portal, ongoing frequent training
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes? Preferred providers could be those that are already participating in ACOs—Share data
- How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful? CM for high risk members
- How should MCOs work with providers to ensure timely access to care standards are met? What are reasonable time and distance standards in Oklahoma by provider type? 30 miles within 24 hours---Primary care visits within 30 days of request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care-some same day urgent care –Specialist and BH within 60 days of request
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? Comparable reimbursement-Fair payment
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers? Loan repayment programs-ongoing training

- How should MCOs work with providers to ensure timely access to care standards are met? Monthly reports on standards evaluation should be sent to make any improvements and ensure timely access to care standards are met.

Questions for Stakeholder Input: Network Adequacy

- What are reasonable time and distance standards in Oklahoma by provider type? 30 miles
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? MCO's can create a portfolio with success stories of implementation in the pilot phase to recruit more providers.
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers? Ongoing training on best practices to support value based pay

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored? An interactive feedback system or an online chat system will be an option to address the concerns quicker. Proactive approaches such as one-to-one feedback system which can record feedback immediately after the case-manager contacted the patient can be one of the solutions to address this issue.—frequent auditing
- How can the state and MCOs use appeals data to improve utilization management and access? Doing extensive analytical research to find potential risk factors and high-appealing population which will lead to target based management approach can improve utilization management and access.

-

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care? Available networks-all info should be shared--HIE
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? There should not be providers with limited technology—HIE-Password protected/encrypted provider portals
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed? member fraud--monitor ER visits, and limit the number of visits per month. Provider fraud--record audits, spots check with members about billed visits—integrated data system with all transactions made by the member in one system
- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? IDK, yes

DaVita, Inc.
2000 16th Street
Denver, CO 80202

Jeremy Van Haselen
Vice President, Government Affairs

VIA ELECTRONIC SUBMISSION **(Procurement@okhca.org)**

August 21, 2020

Kevin Corbett, CEO
Oklahoma Health Care Authority (OHCA)
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: Comprehensive Medicaid Managed Care Implementation, Reference 80720200002

Dear Mr. Corbett:

DaVita Inc. (DaVita) appreciates the opportunity to submit comments in response to the Request for Public Feedback in Program Design on the SoonerCare Comprehensive Managed Care Program (Request). DaVita is a dialysis provider providing quality life-saving care to patients diagnosed with end stage renal disease (ESRD). DaVita has the privilege of caring for individuals on dialysis across our 2,650 outpatient clinics nationwide, 51 of which are located in Oklahoma. DaVita serves approximately 900 SoonerCare beneficiaries throughout the state. These beneficiaries suffer from a serious chronic illness, often accompanied by numerous comorbidities, and require significant medical care. Generally, ESRD patients require three dialysis treatments every week in addition to numerous prescription drugs, labs, and other care. Because of this, DaVita wishes to make certain comments designed to ensure any change in the SoonerCare program does not negatively impact quality care that is required for ESRD patients.

I. Clearly Communicate With SoonerCare Members & Providers About Transition to Managed Care

In its Request, the Oklahoma Health Care Authority (OHCA) outlines its plan to require certain populations to enroll in managed care organizations (MCOs) right away, while other populations will initially remain in fee-for-service, and be transitioned to managed care over time. One such population that will be transitioned to managed care in the future are "dual-eligibles" – individuals enrolled in both Medicare and Medicaid. The vast majority of SoonerCare members with ESRD fall into this dually-eligible population.

As Medicaid programs in other states have implemented managed care, and similarly phased dual-eligible beneficiaries into MCOs over time, DaVita has observed various implementation challenges. Based on these experiences we recommend OHCA require that MCOs have a clearly defined transition process and communications strategy both for those beneficiaries who will be enrolled immediately as well as those who will be transitioned at a later time. Topics that MCOs should address include:

- How the transition will be implemented;
- The types of notice and communications that MCOs will provide to SoonerCare members about the transition;
- Whether SoonerCare members will have an opportunity to choose a plan or be auto-enrolled in one; and
- The process for SoonerCare members to change their plan (particularly if members will be auto-enrolled).

Additionally, MCOs should be required to have a clear strategy and timeline for communicating with SoonerCare participating providers, particularly in regards to aspects of the transition that impact them. Among other topics, some aspects would include provider reimbursement, how the MCO plans to handle beneficiary transportation for medical care, and any other administrative changes that providers need to be aware of when the conversion to managed care is made. Ensuring that MCOs have planned for the transition process, and clearly communicated about that process to both SoonerCare members and participating providers, will help to reduce disruptions in care for SoonerCare members with ESRD.

II. Maintain Current Level of ESRD Care In Benefits Provided Through MCOs

In its Request, OHCA indicates that "[m]anaged care enrollees will receive the same benefits and services they receive currently, plus some extra benefits." Generally speaking, DaVita recommends that MCOs be required to replicate current access and benefit levels provided in the fee-for-service environment. Challenges arise, and ESRD beneficiaries are negatively impacted, when benefit levels or other program policies vary from the current approach in fee-for-service. DaVita makes the following recommendations to ensure that the level of benefits and services for ESRD beneficiaries is maintained.

First, DaVita recommends that OHCA prevent MCOs from containing program costs by varying benefits packages for different members, based on medical factors or other considerations. DaVita does not support

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the focused delivery of benefits so that members receive the care most relevant for their needs, as this could lead to less comprehensive coverage for ESRD patients who – by definition – require extensive resources for very specific health needs.

Second, DaVita has concerns with the reference to "extra benefits," as this potential flexibility afforded to MCOs could result in the elimination of "extra" benefits that are especially critical to certain patient groups, such as individuals with ESRD. Should the final program design include such flexibility for MCOs, DaVita recommends they be required to obtain OHCA approval in advance of any changes to benefit offerings or, at a minimum, OHCA retain the right to review such changes. Such oversight will ensure that critical benefits are not being reduced or eliminated.

Third, DaVita recommends that MCOs maintain the fee-for-service policy of not requiring prior authorization for dialysis services. To the extent prior authorization is required for access to certain out of state services, we recommend that MCOs be required to follow Oklahoma's existing policy in order to minimize variation from the current level of access available under fee-for-service and ultimately among MCO plans.

Additionally, in response to OHCA's explanation that "medical necessity will continue to be used to guide the appropriateness of services," DaVita recommends that the current definition of "medical necessity" be revised to eliminate the requirement that services "be delivered in the most cost-effective manner"[1] as cost-effectiveness does not always equate to the most demonstrably effective treatment. We recommend that, instead, medical necessity be tied to an evidence-based approach that is based on best clinical outcomes and/or best demonstrated clinical practices.

III. Ensure a Robust Network of Participating Providers by Requiring Minimum Reimbursement Levels

In response to OHCA's request for input on levels of reimbursement and provider compensation, DaVita recommends that SoonerCare require minimum provider rates in their contracts with MCOs. As a provider, DaVita is concerned that any potential reductions in reimbursement to the MCOs would trickle down to providers as they submit claims for payment. Any potential such cuts could negatively impact provider

[1] Oklahoma Administrative Code, Title 317:30-3-1(f)(5).

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enrollment and, in turn, access to care for SoonerCare enrollees – a result that would be particularly detrimental to ESRD patients.

Additionally, MCOs should be expected to make available assorted channels for communicating with providers about plan policies and administrative requirements related to claims and billing. Such channels could include web portals or electronic claim management tools. Additionally, it would be very helpful to have MCO specialists assigned to certain provider groups, such as dialysis providers, in order to resolve claim-related questions or concerns efficiently. Other ways that MCOs could support network providers related to billing include: (1) minimizing authorization requirements and frequency; and (2) making available an out-of-network fee schedule, which would provide additional clarity for providers.

IV. Implement Measures to Ensure a Reliable Network of Participating Providers

In response to OHCA's request for input on time and distance requirements by provider type, DaVita recommends that MCOs be required to ensure that SoonerCare enrollees are able to access ESRD treatment facilities within 30 minutes or 30 miles of the individual's home. We recommend strong network adequacy requirements for dialysis care because of the frequency and length of dialysis treatments – that is, typically three times per week, for 3-4 hours per treatment for in-center hemodialysis. Given that life-sustaining medical care is required at this frequency, any disruption in treatment for an ESRD patient can be extremely harmful to the patient and costly to the system. Indeed, missing just one hemodialysis treatment has been shown to increase the risk of hospitalization within the next 30 days by 40%, and the risk of mortality within the next 30 days by 118%.[2] ESRD patients also frequently have multiple comorbid conditions, so the patient must juggle accessing dialysis among visits to other specialty providers – making strong network adequacy requirements for ESRD care even more crucial.

DaVita recognizes that an equal part to achieving network adequacy at the 30 minutes/30 miles level that we have recommended is enrollment by a sufficient number of specialty providers in the SoonerCare program. MCOs' challenges in recruiting specialty providers – ESRD providers among others – are more detrimental to ESRD patients given the specialized care that they require. To address these challenges, DaVita recommends that MCOs be required to engage in various strategies to address provider enrollment. Most significantly, MCOs should be required to support enrolled providers in obtaining Medicaid

[2] *In Center Hemodialysis Absenteeism: Prevalence and Association*, DaVita Clinical Research, May 25, 2016.

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certification for new health care facilities. In other states, it is not uncommon for the Medicaid certification process to take up to one year for new DaVita facilities. Requiring MCOs to support the facility inspection and survey processes – for example, by assisting the provider with preparation of the Medicaid enrollment application – could greatly reduce this wait time and help ensure an adequate network for SoonerCare enrollees. Additional strategies that MCOs could be required to engage in to support provider enrollment include financial incentives for specialty provider participation, automatic assignment of members to Primary Care Physicians, and prompt payment policies. DaVita recommends that MCOs be required to engage in these types of activities in order to recruit and maintain Medicaid program participation by specialty providers.

V. Standardize Mechanisms to Facilitate Appropriate Data Sharing

A barrier that DaVita regularly encounters with respect to data sharing is the inconsistent – or even misguided – interpretation of applicable privacy and security laws or regulatory requirements. OHCA and MCOs could streamline data sharing, while maintaining appropriate privacy and security, by requiring a standardized approach for permissible disclosures that are compliant with applicable privacy laws. For example, disclosures to providers for treatment, payment, or health care operations should be honored in a standardized and consistent way. Expanded guidance designating the technical requirements and specifications that adequately safeguard patient information – including a reliance on federal security standards or industry frameworks (for example, the NIST Cybersecurity Frameworks) – could drive consistent expectations among health care providers for compliant technical security safeguards. A uniform, practical approach for responding to requests for permissible disclosures related to SoonerCare patients would reduce logistical confusion and barriers that ultimately impact patient care and coordination among providers – something that is particularly important for ESRD patients – without creating patient privacy or security risks.

Additionally, we believe the following mechanisms are additional ways to streamline data sharing while protecting patent privacy and security. First, we recommend that Oklahoma allow for expanded data sharing for care coordination or telehealth purposes. In 2020, providers have learned that care coordination and remote patient care technology (for example, telehealth) are necessary for ensuring patients receive adequate treatment, particularly in times of crisis. Further guidance and expanded opportunities for efficient and compliant data sharing techniques applicable to new technologies or coordinated care would benefit

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both SoonerCare patients, as well as providers. Additionally, DaVita recommends that Oklahoma join other states for a uniform approach to telehealth and HIE services. Recently, western states like Colorado, Nevada, Oregon, and Washington have agreed to coordinate efforts for telehealth, coordinated care, and population health activities. Oklahoma might consider joining these and other states in the region to foster enhanced approaches and consistency among providers and payers.

VI. Conclusion

DaVita respectfully requests that OHCA consider the impact that a shift to statewide Medicaid managed care will have on ESRD patients. Specifically, we ask that MCOs be required to account for the following in their proposals: (1) planning for and communication with SoonerCare members and providers regarding the transition from fee-for-service to managed care; (2) implementation of measures to maintain adequate benefit levels for ESRD patients, specifically in exercising oversight on flexibility granted to MCOs to tailor benefits, consistency in prior authorization requirements, and by tying medical necessity to clinical best practices instead of cost; (3) support providers through minimum reimbursement rates and direct channels for MCO-provider communication; (4) ensure an adequate network of participating providers through (a) a 30 minute/30 mile requirement for specialty providers and (b) implementation of measures to recruit providers to SoonerCare participation; and (5) promote streamlined and appropriate data sharing by standardizing the requirements for permissible disclosures of patient data. ESRD patients are a highly vulnerable group who would be deeply affected by any reduction in services or access to care, and we feel strongly that protecting their interests is of utmost importance. We appreciate your consideration of our comments and welcome the opportunity to discuss our concerns.

Sincerely,

Jeremy Van Haselen
Vice President, Government Affairs
(713) 423-1900
Jeremy.VanHaselen@davita.com

Questions for Stakeholder Input: Enrollees

- How and when should OHCA transition ABD and other initially excluded individuals to managed care?

  This decision should be made with oversight and input from the Oklahoma Department of Mental Health and Substance Abuse Services. Enrolling this population too quickly without significant strategy and understanding of the possible outcomes could put this vulnerable population at high risk. For this population, the MCOs should be required to contract with all CCBHCs/CMHCs as they have the ability to provide the best care for the ABD population and are fully aware of the system in place for level of care changes and best practices in treating this population. They also serve as the "safety net" as individuals roll on and off of Medicaid.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

  MCOs can better engage individuals by providing incentive payments to providers that that coordinate care and focus on these outcomes.

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

  MCOs should not put any barriers on providers for delivering services via telehealth and should assist providers in doing so.

- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

  Referrals should be well documented and followed up to ensure referrals are successfully made.

- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

  By assuring that MCO contracts with providers that have this expertise. MCOs should assure that experienced providers are available to provide Medication Assisted Treatment and PACT services.

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

  Require MCOs to contract with providers that have expertise in specialty services such NAVIGATE, IPS, Systems of Care, PACT, wellness programs , etc. and pay for those models of care.

- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

  There should be adequate transportation available especially in the rural areas. Uber and Lyft are good alternatives. Telehealth services should also be available without barriers.

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes?

  Continue the ETPS payments to CCBHCs and CMHC for strong outcomes.

- What are the most important indicators of MCO performance? Why? What measures of health outcomes should be tracked?

  That consumer outcomes are strong using the required standards for CCBHCs and the ODMHSAS.

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers?

  Those providing utilization reviews for the SMI/SED/Addiction should be clinical staff that understand best practices.

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden?

  The more consistent the process the better. It is critical that MCOs are required to do agency credentialing rather than individual credentialing for staff, particularly for CMHCs/ CCBHCs that already have external requirements that staff meet licensing or certification requirements along with training requirements. Individual credentialing can be a huge administrative burden that serves no real purpose. For the SMI/SED/Addcition population, prior authorizations should be long enough as to not be burdensome given these populations will likely need longer care than the general population.

Questions for Stakeholder Input: Member Services

- What metrics should be used to measure MCO performance with regards to member services?

  ETPS measures and CCBHC measures should be used.

Questions for Stakeholder Input: Provider Payments and Services

- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

  Rates cannot be lower than they currently are unless good incentives are available for outcomes that can make up the difference. CCBHCs should be able to keep their PPS rates.

- What is appropriate for timely payment of claims?

  Thirty days.

- What provider services functions or processes should be standardized across MCOs? How should this be accomplished? What are the barriers to standardizing the function and how should these be addressed?

  Using the same forms for credentialing and making credentialing by agency, not individual credentialing. Any other standardization that is logical should be required.

- How can MCOs best communicate to providers about updates and changes to plan policies?

  MCO's cam best communicate to providers with frequent updates via email and written notices as well as a website that is easy to navigate and find relevant information. It should be easy to communicate via a live person with quick access to asking questions and resolving issues.

Questions for Stakeholder Input: Network Adequacy

- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid?

  Pay no lower than Medicaid/ODMHSAS rates and allow CCBHCs to keep their PPS rates.

Questions for Stakeholder Input: Grievances and Appeals

- How can MCOs and the state receive feedback and be accountable for addressing member concerns? Are there proactive approaches that should be explored?

  There should be strict time limits for resolving grievances (15-30 days). There should be an appeal process that ideally would comprised of members and perhaps providers.

- How can the state and MCOs use appeals data to improve utilization management and access?

This should be closely monitored by the OHCA and standards/recommendation should be set.

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

  Providers should be given access to relevant information to provide integrated care and to be able to coordinate care using the information to provide the best care. This would include physical health data, prescriptions and information from previous care with HIPAA safeguards in place.

- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?

  There should be strong collaboration between ODMHSAS, OHCA and the MCO with metrics in place.

From: Crystal Rios
To: OHCA Procurement
Subject: [EXTERNAL]
Date: Monday, July 20, 2020 5:01:41 PM

Good afternoon,

I have a question about moving sooner care to managed care for behavioral health. I have an agency that is accredited by the department of mental health. Will this accreditation mean anything in the future? Will managed health care accept this accreditation, since it is not a national accreditation? If not, we have 600 clients that will be out of services

Thank you,

Crystal Rios

From: Crystal Rios
To: OHCA Procurement
Subject: [EXTERNAL]
Date: Monday, July 20, 2020 5:41:51 PM

Good afternoon,

Right now, as a soonercare provider, we are able to have case management and rehab as services that managed health care organizations don't offer. Is this going to effect mental health candidates? Right now, you are required as a licensed clinician to do two years of work under a supervisor, and are able to see only soonercare. Will this be allowed or will the have to do this at only hospitals, which was the case, the first time Oklahoma tried this. I'm also wondering about all the organizations accredited by DMH, will those still be sufficient? We need more providers in the outpatient area as it is. Preventative health is key.

Thank you,

Crystal Rios

How and when should OHCA transition ABD and other initially excluded individuals to managed care? If you are going to transition them for sure, there is no need to wait

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups? yes
- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? Make compliance a condition of continued enrollment. What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care? Transportation options, telehealth accessibility and reimbursement for telehealth services
- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing? (required?) Partnerships between medical and behavioral health facilities that do not have integrated services
- How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? By closing the loop on these types of referrals, similar to how we have to do this when referring patients to specialty care—we must be able to provide documentation that the referral occurred and the outcome. How could OHCA measure MCO performance on social risk factor mitigation strategies? Same way, close the loop
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment? By utilizing community health centers that already have this in place. Our CHC has every bit of this in place.
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction? Case managers?
- How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments? That works in the urban areas, but Uber and Lyft are not available in most rural areas. Maybe incentives for people to drive for these types of companies in rural areas.

What mechanisms should the state use to incentivize MCOs to improve member outcomes? Is there an ACO type model for MCOs?

- What are the most important indicators of MCO performance? I would think that they should be held to the standards of PCMH, UDS, etc. Why? Everyone should be somewhat on the same page.
- What measures of health outcomes should be tracked? As above.

How can utilization management tools work best for members and providers? The MCO would need a reliable way to communicate the ongoing progress and needs of the members, such as an electronic communication interface

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden? consistent goals and communication techniques/platforms across the board.

- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs? call in lines to reduce ER utilization for BH purposes
- How can MCOs improve the management and coordination for members with chronic or complex health conditions? direct communication with the providers in charge of the patient's care.
- What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations? assign care managers within the MCO or within the PCP office if available.

What metrics should be used to measure MCO performance with regards to member services? patient engagement surveys, provider surveys

- How can MCOs best serve individuals who primarily speak a non-English language? have translators available for use in the clinics. Individuals who may not understand health care terminology? provide information on a lower educational level
- How can MCOs use technology (such as web-based applications and mobile phones) to help members with their health care needs? health apps, telehealth platform applications
- How can MCOs best communicate with members who do not have a mobile phone, computer or reliable internet service? phone? home visits?
- How can MCOs communicate with members and receive regular input and feedback on program improvements? phone, chat platform, portal
- What tools and resources would help members search for providers? website, portal, app with updated lists. What information should be provided? general information about the clinic/provider, services available.

How should MCOs work with providers to ensure timely access to care standards are met? set standards for availability. providers participating currently should already have this in place.

- What are reasonable time and distance standards in Oklahoma by provider type? for primary care, should be within 30 miles and available within 24 hours.
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? comparable reimbursement
- How should MCOs support workforce development for different types of providers, including pediatric dentists, pediatric psychiatrists, primary care providers, and behavioral health providers? it would be great to offer loan repayment programs for service.

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? use available data sharing networks already in place. please do not develop a whole new platform that has to be learned and accessed separately. What data should be shared between MCOs and providers to facilitate patient care? all of it?
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? multiple platforms on which data must be accessed. there should really not be providers with limited technology.
- How can MCOs help identify member and provider fraud? member fraud--monitor ER visits, and limit the number of visits per month. Provider fraud--record audits, spots check with

members about billed visits. What methods of fraud prevention and detection should be deployed? as above

- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? I don't know

-

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design

Planned Comprehensive Medicaid Managed Care Implementation

On June 18, 2020, Governor Kevin Stitt and Oklahoma Health Care Authority (OHCA) CEO Kevin Corbett announced that the state would seek proposals from qualified managed care organizations (MCOs) to improve health outcomes, increase access to care, and increase system accountability in the Medicaid program (SoonerCare). The Request for Proposals (RFP) is currently in development, with a planned release this fall and an anticipated implementation date of October 1, 2021. OHCA is establishing requirements and is seeking stakeholder input prior to finalizing the RFP. OHCA will accept responses from any interested party including individuals and program participants, providers, trade associations, companies and other organizations. Responses need not address every question. Responses should be submitted by 5:00pm Central Time on August 21, 2020. Responses should be submitted via email to Procurement@okhca.org and can be submitted as a letter attachment. Please reference 80720200002 in the subject line of your response.

Comprehensive Managed Care for Oklahoma: A Key Tool for Program Improvement

Oklahoma is pursuing a comprehensive Medicaid managed care approach that will allow the state to achieve its payment and delivery system reform goals:

Improve health outcomes for Oklahomans

Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume

Improve member satisfaction

Contain costs through better coordinating services

Increase cost predictability to the state

The following sections provide information on the planned managed care program and identifies areas where additional input is requested.

Managed Care Enrollees

Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

To improve health outcomes, children, low-income parents, pregnant women, and adults ages 19-64 (expansion population) will be required to enroll in MCOs, which will be responsible for their access to and quality of care.

- Individuals enrolled in SoonerCare due to their status as "Aged, Blind, or Disabled" (ABD) will initially remain in fee-for-service
- Senior citizens and people enrolled in both Medicare and Medicaid ("dual eligibles") will initially remain in fee-for-service Medicaid
- Individuals who transition to long term care in a nursing facility or ICF/IDD will be disenrolled from the MCO after 60 days in an institutional care setting
- MCOs will serve members across the state

To ensure that each member has a health plan responsible for their care and health, the SoonerCare application will include a choice of plans. People who do not choose a plan will have one assigned. Members will have opportunities to switch plans.

Questions for Stakeholder Input: Enrollees

- Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups? Response: Bifurcated management does not address Oklahoma behavioral health

needs as an integrated system of care. MCOs should be experienced and capable of administering care for all populations.

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier? Response: MCO can make technologies available to educate, support, and reward patients who demonstrate improvement in healthier behaviors. MCO should identify high risk members based on their data and provide those individuals with additional care coordination or other customized MCO-sponsored programs.

Benefits Provided through MCOs

Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits. The MCOs will manage physical health, behavioral health, vision, and non-emergency medical transportation for their members. Members will not need a referral to receive pregnancy care, behavioral health, vision, family planning, emergency care and care from Indian Health Care Providers for AI/AN members. In addition, MCOs may offer "value added" benefits that are not available in traditional Medicaid, such as additional medical supplies and health and wellness incentives.

SoonerCare will continue to use an evidence-based approach to care, and medical necessity will continue to be used to guide the appropriateness of services. Delivered services will be consistent with accepted prevention, diagnostic and treatment practices.

AI/AN members in managed care will continue to have access to Indian Health Service (IHS) or Tribal health care providers of their choice.

To ensure **appropriate and sufficient behavioral health care**, each MCO must:

- Allow reimbursement for co-location of physical health and behavioral health services
- Operate a behavioral health crisis line and coordinate with the statewide crisis line where applicable
- Integrate behavior and physical health

To help members address the root causes of many health issues, MCOs will be required to engage in **Social Determinants of Health strategies**, including:

- Screening enrollees for social needs
- Providing enrollees with referrals to social services and tracking the outcomes of referrals
- Partnering with community-based organizations or social service providers

- Requiring employment of community health workers or other non-traditional health workers

Questions for Stakeholder Input: Benefits

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care? Response: MCOs should frequently monitor provider access and availability through required provider attestation, secret shopper calls, etc. Phantom provider networks do not provide patients access to care. Additionally, MCOs should reduce the amount of administrative requirements as providers enter their network. MCOs should use technologies to make instant and accurate patient eligibility available to providers, showing real-time benefits including limitations and maximums. Patients would also benefit if MCO was required to reinvest dollars back into the community.
- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment? Response: Bundle MAT services together for authorization and payment. MCOs can tier providers or assign special designation to providers for providing evidence-based care.
- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction? Response: Value-Added Certified Peer Support Services for individuals with a substance use disorder. Days Awaiting Placement / Administratively necessary days for patients who are difficult to place or unable to discharge/step-down due to MCO's network unavailability.

Quality and Accountability

MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

OHCA will require MCOs to support the agency's quality goals and actively improve access, quality of care and health outcomes for SoonerCare members.

- Areas for quality measurement include population health goals identified as **state priorities: tobacco use, opioid-related overdose deaths, childhood obesity, behavioral health access, diabetes, cardiovascular disease, infant mortality and pregnancy outcomes**
- MCOs will **reimburse providers using a methodology with a performance-based component** that incentivizes outcomes for state-priority conditions
- **OHCA is investigating the use of incentive measures, quality pools and other programs;** MCOs will participate in OHCA efforts to provide enrollees access to quality health care

Questions for Stakeholder Input: Quality and Accountability

- What mechanisms should the state use to incentivize MCOs to improve member outcomes? Response: Partial withhold for MCO's PMPM.
- What are the most important indicators of MCO performance? Why? Response: Improved member outcomes, stabilized and more predicable healthcare costs, increased quality and efficiency.
- What measures of health outcomes should be tracked? Response: HEDIS measures like 7-Day post-hospitalization appointment scheduled and 30/60/90 recidivism.

Care Management and Coordination

MCOs have experience managing members' health, including for populations with complex or multiple needs. Medicaid MCOs work under federal utilization and care management requirements. OHCA is also developing state requirements and standards for MCOs regarding:

- Prior authorization (PA): services subject to PA, timeliness standards for approval
- Use of practice guidelines
- Utilization management program standards

To support providers' efforts to organize patient care and appropriately share information among providers engaged in a patient's care, MCOs will be required to:

- **Conduct health screenings** to identify ongoing need, current providers, and social determinants of health
- **Develop care plans** for identified enrollees and **establish care management and care coordination** based on identified risk and particular health conditions
- **Design health management programs** with a holistic approach to member health
- **Conduct health education** in priority areas and on emerging issues

In addition, MCOs will support **Patient Centered Medical Homes** under a re-design that utilizes a value-based strategy that includes integration of behavioral health and social determinants, enhanced care coordination payments and performance measurement.

Questions for Stakeholder Input: Care Management and Coordination

- How can utilization management tools work best for members and providers? Response: MCOs be required to administer standardized industry-approved tools like ASAM or LOCUS and provide transparency of criteria used to providers. MCOs be barred from using medical

necessity criteria developed in-house. MCO assign reviewers to participating provider vs. UM caseload management through a call-in queue.

- How should the state encourage or require consistency across MCOs in the utilization management process to reduce provider administrative burden? Response: Requiring consistency across MCOs is paramount for provider and member success. State should mandate (within regulatory allowance) key areas that reduce access to care and administrative pain points that take clinicians away from patient care.
- What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs? Response: MCO must maintain both an accessible and available network of providers. Community and Outpatient services with long waiting lists or programs/clinicians that are no longer accepting new patients need to be suppressed from provider directory.

Member Services

Medicaid MCOs must follow federal rules for providing responsive and meaningful member assistance, to include:

- **Answer member questions timely** via telephone or email and resolve grievances and appeals timely
- **Frequently update provider directories** online to help members locate health care providers
- **Provide member materials** in the prevalent non-English languages and ensure written materials are easily understood by individuals of varying literacy levels

Questions for Stakeholder Input: Member Services

- How can MCOs best serve individuals who primarily speak a non-English language? Individuals who may not understand health care terminology? Response: Publish member materials at the lowest grade level possible and in multiple languages, offer text or chat services to members vs. only phone assistance.
- What tools and resources would help members search for providers? What information should be provided? Response: Online provider directory should contain provider's demographic information, services offered, and specialties and populations treated. Online directory should hyperlink to provider's website so members do not have to exit the directory and search for the provider's website on their own. Additionally, as MCO collects information on provider's quality, efficiency, and availability – display those features in provider directory as well.

Provider Payments and Services

Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

- As required by CMS, do not pay a provider for provider-preventable conditions
- Continue to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the current Prospective Payment System, until/unless an Alternative Payment Methodology is developed
- Pay Indian Health Care Providers at the encounter rate whether or not they are in network
- Non-network Indian Health Care Providers can refer an AI/AN patient to a network provider
- Require MCOs to credential health care providers timely while verifying their credentials and checking for a history of health care fraud
- Maintain and/or expand telehealth availability

Questions for Stakeholder Input: Provider Payments and Services

- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation? Response: Yes, the state must mandate a minimum level of reimbursement. That minimum level must be current within market. Minimum levels must be published online for transparency. MCO should establish payment continuum that rewards for performance before moving to risker types of arrangements. All models should be behavioral health specific. Regardless of value-based movement, MCO still needs to keep up with cost of living adjustment to base reimbursement or align base rates with year-over-year changes announced by CMS.
- What is appropriate for timely payment of claims? Response: 30-45 days is reasonable for timely payment of claims.
- How can MCOs best communicate to providers about updates and changes to plan policies? Response: Hold provider forums and make online playbacks available. MCOs must notify provider of all material changes via multiple avenues (i.e. newsletter, online bulletins, email, and mail).
- How can MCOs help providers navigate plan administrative requirements for activities such as submitting claims or resolving billing issues? Beyond contracting and billing issues, what kinds of supports could MCO provider services staff offer to network providers? Response: MCO rely less on claims customer service queue and invest in claim subject matter experts that are made available to provider so troubleshoot billing issyes.
- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes? Response, MCOs work with provider to advance according to provider's level and not before provider is ready. Sharing data with providers is key. MCOs work with providers based on learned experience to implement changes without increasing administrative expense or hiring additional FTEs.

Network Adequacy

Because access to providers is a cornerstone of appropriate and adequate care, MCOs must ensure members receive timely access to care, including:

- Examples of industry standards include:
  - Primary care medical home appointments within 30 days from request for routine care, 72 hours for non-urgent sick care, 24 hours for urgent care
  - Specialist and behavioral health appointments within 60 days from request for routine care, 24 hours for urgent care
  - Require all Primary Care Providers have at least some same-day acute care appointments
  - Availability of services within time and distance proximity standards to most members' residences, differentiated by provider type (ex. in-network specialists available within 60 miles or 60 minutes of most members' residences)

- Show the MCO has sufficient Indian Health Care Providers in its network to ensure timely access to services to these providers for AI/AN enrollees

Questions for Stakeholder Input: Network Adequacy

- What are reasonable time and distance standards in Oklahoma by provider type? Response: 60 days is too long to wait to receive behavioral health services for any provider type.
- How should MCOs recruit more health care providers in Oklahoma to participate in Medicaid? Response: MCOs should recruit when network demands but without diluting patient referrals to existing quality providers.
- ?

Grievances and Appeals

To ensure accountability to the state and SoonerCare members, MCOs must meet OHCA and federal requirements for timely and meaningful grievances and appeals processes. Grievances and appeals can be filed by members or providers on their behalf.

- MCOs will resolve appeals within 30 days for standard requests and within 72 hours for expedited requests
- MCOs will resolve grievances in writing within 30 days

Questions for Stakeholder Input: Grievances and Appeals

- How can the state and MCOs use appeals data to improve utilization management and access? Response: MCOs should have frequent auditing of both criteria and application of criteria. State can establish denial & appeal threshold based on industry norms to hold MCOs accountable and adjust utilization management practices when numbers fall outside threshold. MCOs should make modified and/or reduced utilization management protocols available for providers who demonstrate a high level of clinical concordance with MCO's criteria.

Administrative Requirements

OHCA will hold MCOs to high standards for responsiveness and accountability by requiring Medicaid MCOs:

- **Gain accreditation** by a federally-approved accreditation body (NCQA, URAC, AAAHC)
- **Maintain an Oklahoma presence,** including having plan operations in Oklahoma and an office located no more than 100 miles from OHCA, at which executive team and key staff work
- **Participate in the state Health Information Exchange** to allow the MCOs and providers to improve care by eliminating redundant tests and procedures, support care coordination and transitions, and facilitate the exchange of electronic health records and care plans

Questions for Stakeholder Input: Administrative Requirements

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care? Response: Providers would benefit from receiving reports containing patient co-morbidities and clinical information from patient's PCP.
- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology? Response: Many Behavioral Health providers do not use Electronic Health Records due to the cost of implementation. Password protected/encrypted provider portals are a vehicle for data sharing.
- How can MCOs help identify member and provider fraud? What methods of fraud prevention and detection should be deployed? Response: Providers benefit from receiving education from MCOs on trends identified. Deploying pre-payment reviews prior to the founding of a network integrity issue, puts unnecessary restraints on providers. Criteria for post-payment review and protocols MCO follows for pre or post payment review must be transparent.

MCOs should provide billing education and FWA early detection seminars to contracted providers.

- Should the state require MCOs to offer health plans on the Oklahoma Health Insurance Marketplace? Response: Yes.

SoonerCare Comprehensive Managed Care Program
Feedback

Managed Care Enrollees: Managed Care enrollment will provide SoonerCare members with better access to a system that is more coordinated and has greater cost predictability.

1. How and when should OHCA transition ABD and other initially excluded individuals to managed care?
    a. Do not transition until the MCOs can prove they have contracted with already established community organizations, such as Health Access Networks to allow for whole person care. This care should go beyond telephonic resources.

2. Should the state require each MCO enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?
    a. Must be responsible for everyone.
    b. Pull: Health Care Fragmentation in Medicaid Managed Care vs. Fee for Service Population Health Management Vol. 23 NO.1 **Published Online:** 30 Jan 2020 https://doi.org/10.1089/pop.2019.0017
    c. https://www.ncmedicaljournal.com/content/80/5/312.full

3. How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?
    a. Enhance the focus on early childhood interventions – where research unequivocally tells us the biggest impacts can occur.
    b. Adapt efforts to be more responsive to the impact of racial disparities on families and children.
    c. Require utilization of a multifactor approach, working with key stakeholders and members of the community to implement programs that address the physical and behavioral health needs of members while addressing barriers to access.
    d. Recognize the value of strong relationships with leaders in the community to gain insights and knowledge of local market and population needs.
    e. Focus on value-based care instead of volume-based care, with special focus on social determinants of health to address member needs in a holistic way. Target underlying causes of health-related challenges, including affordable housing, behavioral health, care coordination, job training, and access to healthier food. Recognize that achieving health is a multifaceted problem.
    f. Require evidence of "philosophy of engagement" which should include inclusiveness, person-centered care, people first language, and whole person care
    g. If Sooner Care 2.0 is implemented, allow SoonerCare members opportunities for premiums, co-pays, and other costs to be waived.

Benefits Provided through MCOs: Managed care enrollees will receive the same benefits and services they receive currently, plus some extra benefits.

1. What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

    a. Issues accessing health care is often about more than a desire or an inability. Health literacy is an important part. MCO's must be required to learn about their members, the communities where they live, and develop programs that help educate from early ages the importance of health care. These programs cannot be punitive. MCO's should be required to utilize programs already developed and established within communities, to help with access such as Healthy Steps, Heath Access Networks, etc.
    b. Building community networks.
2. What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, share assessments and planning, and data sharing?
    a. Use of an HIE, but with expanded coverage of community services and care management information. Care plans from all programs need to be shared through the HIE.
3. How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor migration strategies?
    a. Use of a common referral tracking tool agnostic of any one EMR or other system. A referral tool such as the one utilized by the Health Access Networks, that is web based, easy to use, can interface with other systems and is agnostic of any EMR.
    b. Having the ability to track referrals to social groups is vital to measure the success of the MCO in addressing social issues.
    c. MCO's should be required to utilized groups well trained in addressing social issues or at a minimum the MCO must provide evidence of staff completing cultural consciousness training and addressing social needs.

4. How can MCO's improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?
    a. Incentivize incorporation of evidence-based best practices for behavioral health screenings in all post-partum situations, requiring follow up treatment.
    b. MCO's should be required to contract with groups such as the Oklahoma Primary Healthcare Improvement Cooperative
    c. True community based behavioral health
5. What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?
    a. Comprehensive case management or centralized navigational support for vulnerable populations
    b. In home therapy
    c. In home primary care services
    d. Caregiver support and services
    e. Standardized training
    f. Member and caregiver education

6. How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?
    a. Yes, and needs to be expanded
    b. Need to be able to book rides for same day appointments
    c. Ability to travel with children - always

Quality and Accountability: MCOs will be held accountable for providing members with quality care that improves their health. OHCA will collect MCO data and assess plan performance on process and outcome measures.

1. What mechanisms should the state use to incentivize MCOs to improve member outcomes?
    a. Use of established community programs, such as healthy steps, Health Access Networks
    b. Performance pay plans – adjusting for risk groups
        i. Incentives for not just providers but other groups involved as well
2. What are the most important indicators of MCO performance? Why?
    a. Patient Satisfaction
    b. Outcome measures – such as lower A1C, early childhood developmental metrics, school readiness and progress
    c. Provider satisfaction
3. What measures of health outcomes should be tracked?
    a. Member satisfaction

Care Management and Coordination: MCOs have experience managing members' health, including for populations with complex or multiple needs.

1. What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?
    a. Home based behavioral health needs
    b. Coordination of care efforts including comprehensive case management
2. How can MCOs improve the management and coordination for members with chronic or complex health conditions?
    a. Utilization of successful community programs already in place such as the health access networks

Member Services: Medicaid MOCs must follow federal rules for providing responsive and meaningful member assistance

1. What metrics should be used to measure MCO performance with regards to member services?
    a. Outcome measures – such as lower A1C, healthy births, early childhood developmental metrics, school readiness and progress

Provider Payments and Services: Each MCO must meet OHCA and federal requirements, including negotiating provider rates that ensure member access to care.

1. What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?
    a. Quality Communities
2. How can MCOs support primary care providers in caring for their patients? What infrastructure, programs, training or coaching would be useful?
    a. Training – Standardized Care Management
    b. Practice Facilitation

August 18th, 2020

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback in Program Design - 80720200002

To Whom It May Concern:

This letter serves to provide input requested by the Oklahoma Health Care Authority in relation to its Request for Public Feedback in Program Design for its proposed SoonerCare Comprehensive Managed Care Program.

Pharmacy Providers of Oklahoma (PPOk) is a member-owned Pharmacy Services Administration Organization (PSAO) representing 411 Oklahoma community retail pharmacies. PPOk also operates the largest clinically integrated pharmacy network in the country with 132 local community pharmacies in Oklahoma called the RxSelect Community Pharmacy Enhanced Services Network (CPESN®). This clinically integrated network acts as an Accountable Pharmacy Organization focusing on patient care planning involving health risk assessments, monitoring applicable clinical values in relation to therapeutic goals, assuring optimal medication use and adherence, identifying and addressing patient barriers to care, and maintaining associated clinical documentation that can be used by other providers involved in the patient's health care team. This clinically integrated pharmacy network will grow in response to the opportunity to become involved with the SoonerCare Comprehensive Managed Care Program, further increasing access to pharmacy services.

As Oklahoma struggles with significant Health Provider Shortage Areas (HPSAs), PPOk's CPESN pharmacy network can help assure continuity of care via its unmatched level of patient access – 98% of Oklahoma's population resides within 15 miles of a CPESN pharmacy. Oklahoma is in a unique position to partner with its local community pharmacy network to provide full access to prescription dispensing services with the full PPOk network as well as to embrace the enhanced pharmacy services available through PPOk's CPESN pharmacy network. It is through the capabilities of PPOk's pharmacy networks that the following recommendations are respectfully being put forth for your consideration.

Access to Dispensing Services While Avoiding Mistakes Made in Other States

PPOk strongly advocates for transparent management and reimbursement for prescription dispensing services provided to Medicaid recipients. In order to achieve this statutorily defined requirement, PPOk proposes a pharmacy benefits carve-out of any proposed Medicaid Managed Care program. Medicaid pharmacy benefits are better managed through a standardized fee-for-service program managed by a single entity that sets reimbursement rates at National Average Drug Acquisition Cost (NADAC) plus a $13 dispensing fee, the standard currently used by other state Medicaid programs. Establishing a standard transparent reimbursement is critical to avoid the pricing games and the exorbitant profits pharmacy benefit managers (PBMs) have gouged other state Medicaid programs. Millions of wasted taxpayer dollars within Medicaid managed care programs have been identified by state Attorneys General across the country, and a state-by-state detailing of these dollar figures can be found on the chart at the end of

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this letter. To avoid these financial abuses, two states, Texas and West Virginia, discovered that removing PBMs and paying pharmacies directly saves their state Medicaid programs millions of taxpayer dollars. Specifically, the Texas Health and Human Services Commission (HHSC) found that removing PBMs and paying pharmacies directly would save the state $90.3 million dollars per year.[1] The State of West Virginia saves $54 million per year by removing PBMs and infuses $122 million into local economies in the form of fixed professional dispensing fees to pharmacies.[2]

Establish a Clinically Integrated Enhanced Pharmacy Services Program

Pharmacists are a critical component to effective health care management and attainment of quality measures designed to improve patient health outcomes. PPOk believes that partnering with a community-based pharmacy network to create a State-managed quality improvement program focused on improving health outcomes through the use of community pharmacists will accomplish two goals. First, and most importantly, pharmacists can have a significant impact on Oklahoma's health care mission by improving the patient care experience, improving population heath measures, and contributing to reducing per capita healthcare costs over time. Second, a State-managed program will establish performance benchmarks that can be used to assess Managed Care Organization quality improvement programs. Thus, the CPESN clinically integrated network should be part of any managed care program within SoonerCare.

It is worth noting that each year, adverse drug events (ADE) in outpatient settings account for over 3.5 million physician office visits, an estimated 1.3 million emergency department visits and approximately 350,000 hospital admissions in the U.S.[3] Non-adherence to medications alone costs the U.S. 290 billion dollars annually.[4] Many of the determinants of preventable adverse drug events identified by the National Action Plan for ADE Prevention[5], commissioned by the Federal Government, can be impacted by enhanced pharmacy services offered by the CPESN network:

- Limited time in patient / provider interaction for counseling
- Inappropriate monitoring
- Miscommunication between provider and patient
- Medication incorrectly or inappropriately prescribed
- Poor healthcare coordination
- Poor health literacy
- Non-adherence to medications
- Misuse of medications
- Difficult to use materials

Given the PBM abuses listed above, and the costs associated with adverse drug events, there is legitimate cause for questioning the degree to which state Medicaid programs are really saving taxpayers money or achieving necessary health outcomes. A pharmacy carve-out from Medicaid Managed Care plus the establishment of a clinically integrated enhanced pharmacy services program can target these immense cost drivers.

In addition to the recommendations put forth above, the following sections provide input detailed according to the categories described in the Request for Public Feedback:

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Managed Care Enrollees

Question for Stakeholder Input:

- How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

Response from PPOk:

- In conjunction with care managers, utilize a network of community pharmacists to provide regular touchpoints for accountability toward health goals. An accountable pharmacy organization such as CPESN has the Clinically Integrated Network to provide these services to all Medicaid members or to specific populations within Medicaid.

Benefits Provided Through MCOs

Question for Stakeholder Input:

- What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?
- Response from PPOk:
  The community pharmacist is often the most accessible member of the health care team. Pharmacists are trained to provide a significant number of various services that to date are not being provided. Pharmacists should be included as health care "providers" and should be compensated for providing these very important services that are shown to have a positive impact on improving patient outcomes and reducing healthcare costs over time. A few examples of this are tobacco cessation counseling services, vaccine administration, and diabetes education.
- In addition to embracing pharmacists as health care providers, establishing standardized transparent reimbursement for prescription dispensing is key to reversing the alarming trend of pharmacy closure in rural communities. Many communities in Oklahoma depend on the local pharmacy as the only health care resource available. Decreasing reimbursement for prescription dispensing has caused many community pharmacies to close doors increasing the gap in access to care. This issue has been seen across the country, especially in states where Medicaid Programs are outsourced to managed care companies who employ or own PBMs that take a significant spread price and make unconscionable profits while paying pharmacies much less than what they charge the state's Medicaid program for the prescription. Optimizing the role of the community pharmacist while preserving access to the community pharmacy are key in improving and maintaining access to care, and maintaining transparency and accountability in the expenditure of taxpayer dollars.
- Over 98% of Oklahoma's citizens reside within 15 miles of a CPESN pharmacy providing enhanced pharmacy services. With increasing opportunities to serve patients beyond just prescription dispensing, the number of CPESN pharmacies is anticipated to continue its current growth over the next few years.

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Question for Stakeholder Input:

- What strategies would improve the integration of services (especially behavioral and physical health), including through provider communication, shared assessments and planning, and data sharing?

Response from PPOk:

- Utilizing the HL7 standard to communicate health care encounters and services in a patient's health record in a timely fashion would allow all members of the health care team to understand the patient's health and treatment plan and progress towards meeting established goals. Community pharmacists in the CPESN clinically integrated network document their frequent patient encounters addressing patients' medication-related needs and therapy goals in the pharmacist eCare plan using this standard language. The CPESN network aims to improve quality and decrease costs by documenting the pharmacist's interventions in this format. Sharing this type of information along with lab values, vital signs, screenings and chart notes among the care team in a health information exchange (HIE) could improve efficiencies and outcomes in patient care.

Question for Stakeholder Input:

- How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder, or assertive community treatment?

Response from PPOk:

- A network of community pharmacists and staff could provide these services if financial support were available to do so. The infrastructure of pharmacies already exists in our state with 132 Oklahoma pharmacies participating in the CPESN clinically integrated network, which functions as an Accountable Pharmacy Organization to provide enhanced services.
- Several CPESN network pharmacy staff are trained in Mental Health First Aid, with a network pharmacist serving as a master trainer, and the network has a model for the use and training of pharmacy technicians as Community Health Workers.
- The CPESN network operates a service set specifically for the prevention of opioid overdose and is able to share concerns and recommendations with other members of the health care team via the pharmacist eCare plan.

Question for Stakeholder Input:

- What types of value-added services would be most impactful for members in terms of improving health outcomes, prevention and member satisfaction?

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Response from PPOk:

- Rather than being reactive to medication-related problems, pharmacists have the opportunity to intervene to prevent adverse outcomes related to suboptimal medication regimens, patients' poor understanding of medication use, and lack of adherence to therapy. However, the current payment model does not support pharmacists taking an active role in medication management. Optimizing the role of the community pharmacists by reimbursing pharmacists for routine medication check-ups, medication synchronization services, adherence packaging, home delivery, medication reconciliation, and traditional comprehensive medication reviews are a few value-added services that are likely to improve health outcomes, prevention of adverse events such as hospitalization and emergency visits, while improving member satisfaction.

Quality and Accountability

Question for Stakeholder Input:

- What measures of health outcomes should be tracked?

Response from PPOk:

- Health outcome measures that should be tracked include tobacco use status and quit attempts, access to naloxone, HbA1c, blood pressure, asthma control testing, and routine immunizations including influenza, pneumonia, Tdap, and HPV. All of these can be tracked and electronically communicated by local community pharmacies to other members of the health care team as part of the care coordination process.
- Additional health outcome measure tracking should include preventable hospitalizations, hospital re-admissions and emergency department utilization – all of which can be positively impacted by the use of pharmacy services which extend beyond medication dispensing. Community pharmacists conduct services like medication review, collection and monitoring of lab values and vital signs, and provision of such data points to other members of the patient's care team.
- Intermediate measures, such as social determinants of health, provider office visit show / no-show rates, medication adherence and medications added to or adjusted within an existing drug regimen should also be measured and can be impacted by a clinically integrated pharmacy network.

Care Management and Coordination

Question for Stakeholder Input:

- How can MCOs improve the management and coordination for members with chronic or complex health conditions?

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Response from PPOk:

- Patients with chronic or complex health conditions should be assigned a care manager who can keep track of a patient's various providers including primary care, specialists, and pharmacists as an extension of the health care team. These providers should have ability to communicate changes to the patients' status and treatment plan. Partnering with a CPESN pharmacy can involve utilization of staff trained as Community Health Workers and Mental Health First Aid providers with the ability to provide assessments for depression, pain management and social needs for use by care teams and care managers.
- The CPESN network currently is in the final stages of contracting with Arine, a technology company contractor for the Oklahoma Health Care Authority, to provide Medication Therapy Management (MTM) services to high-risk Medicaid members, leveraging the strength of local level relationships with patients and the communities in which they live.

Provider Payments and Services

Question for Stakeholder Input:

- Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished? How should the state sustain provider compensation?

Response from PPOk:

- OHCA should establish standardized reimbursement for prescription dispensing at the current National Average Drug Acquisition Cost (NADAC) plus a $13 professional dispensing fee. In addition, OHCA should reimburse pharmacists for providing enhanced pharmacy services as a provider at the same level as other mid-level providers for services within the pharmacist's scope of practice.

Question for Stakeholder Input:

- What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and improved health outcomes?

Response from PPOk:

- OHCA must establish fair, reasonable, and transparent performance improvement programs that are appropriately designed to reward providers for improving performance. Performance improvement programs that are applicable to community pharmacy should be clinically appropriate, measured transparently, and should be funded outside of the reimbursement for product dispensing. In addition, OHCA should provide for training module videos that assist

providers in understanding the requirements of the program, how performance will be measured, and tips to assist providers in accomplishing target metrics. Set up regional meetings to allow providers to network and collaborate on best practices and recognize local community pharmacy champions.

Network Adequacy

Question for Stakeholder Input:

- What are reasonable time and distance standards in Oklahoma by provider type?

Response from PPOk:

- Dispensing pharmacy access standards are currently defined by statue. See the Patient's Right to Pharmacy Choice Act ("Act") passed unanimously by the Oklahoma legislature in 2019.
- Enhanced pharmacy services should be accessible by patients at a pharmacy within 15 miles of their home. This can be achieved with the CPESN clinically integrated network.
- Patients should be able to ask questions about their medication and receive answers and recommendations from a pharmacist who knows them by name, knows their personal health challenges and opportunities, and shares a presence in their community.

Administrative Requirements

Question for Stakeholder Input:

- How can OHCA and MCOs streamline data sharing but still maintain appropriate patient privacy and security? What data should be shared between MCOs and providers to facilitate patient care?

Response from PPOk:

- Provide free access to the HIE for all providers including pharmacists. Include pharmacist eCare plans in HIE. Update the HIE no less frequently than daily.

Question for Stakeholder Input:

- What are the barriers to data sharing and how can they be overcome, including for providers with limited resources and technology?

Response from PPOk:

- Use an industry-recognized data standard, such as HL7, so that providers can use the system of their choice that follows such data standards. Integrate other features such as a referral system into this tool.

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As discussed in the opening portion of this letter, the next section will provide important references regarding other states' experience with PBMs used by MCOs. This information is courtesy of the Oklahoma Pharmacists Association.

Findings from state audits of Medicaid drug programs regarding PBM activity:
The following list highlights some of the current findings from others states with regard to PBM activity within Medicaid Managed Care programs and highlights the need to create a pharmacy carve-out in order improve transparency and accountability for taxpayer dollars and reduce total healthcare spend.

- Ohio – PBMs found to retain $225 million in spread pricing per year.[6]
- Michigan – Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least $64 million.[7]
- Maryland – A state Medicaid report found that PBMs retained $72 million annually in spread pricing alone.[8]
- Virginia – A state-commissioned report on Medicaid found that PBMs retained $29 million in spread pricing alone.[9]
- Pennsylvania – Between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion.[10]

Thank you for the opportunity to provide input into the model of care for some of our state's most vulnerable populations. It is our shared vision to see Oklahoma improve its health outcomes on multiple fronts which can change the trajectory of countless lives for generations to come. The chart on the final page will provide important references regarding other states' experience with PBMs used by other state Medicaid MCOs and will highlight the need to create a pharmacy carve-out in order to improve transparency and accountability for taxpayer dollars while reducing total healthcare spend. This information is courtesy of the Oklahoma Pharmacists Association.

Sincerely,

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1. DallasNews.com: https://www.dallasnews.com/news/texas-legislature/2019/03/07/house-bills-aim-save-taxpayers-money-kicking-drug-middlemen-texas-medicaid
2. Navigant Consulting, Inc., Pharmacy Savings Report: West Virginia Medicaid 5 (2019), available at https://dhhr.wv.gov/bms/news/pages/west-virginia-medicaid-pharmacy-savings-report-is-now-available!-.aspx
3. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention: https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html
4. Zachry, William. Insurance Thought Leadership.com 2017: https://www.insurancethoughtleadership.com/patients-noncompliance-290-billion-problem/
5. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, National Action Plan for ADE Prevention: https://health.gov/our-work/health-care-quality/adverse-drug-events/national-ade-action-plan
6. Auditor of State of Ohio, Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period (Aug. 16, 2018) https://ohioauditor.gov/news/pressreleases/Details/5042
7. Michigan Pharmacists Association, New Report Highlights Role of Pharmacy Benefit Managers in Manipulating Drug Costs for Michigan Patients, Pharmacists and Taxpayers, (April 29, 2019), available at http://www.michiganpharmacists.org/portals/0/news/releases/final%20MI%20Report%20Press%20Release.pdf?ver=2019-05-01-110013-603
8. Maryland Department of Health, Maryland's 2019 Report on the Maryland Medical Assistance Program and Managed Care Organization that Use Pharmacy Benefits Managers – Audit and Professional Dispensing Fees 3 (Jan. 3, 2020), available at https://cdn.ymaws.com/www.marylandpharmacist.org/resource/resmgr/legislative/mcoauditreport.pdf
9. Virginia Department of Medical Assistance Services, Managed Care Pharmacy Benefit Manager (PBM) Transparency Report 3 (Oct. 1, 2019), available at https://rga.lis.virginia.gov/Published/2019/RD593/PDF
10. Pennsylvania Auditor General, Brining Transparency & Accountability to Drug Pricing 6 (Dec. 11, 2018), available at https://www.paauditor.gov/media/default/reports/RPT_PBMs_FINAL.pdf

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These states audited their Medicaid drug programs to find PBMs siphoning **HUNDREDS OF MILLIONS** of dollars away from programs that support our most vulnerable patients.

1 Pennsylvania Auditor General, Bringing Transparency & Accountability to Drug Pricing 6 (Dec. 11, 2018), available at https /www.paauditor.gov/Media/Default/Reports/RPT_PBMs_FINAL.pdf

Auditor of State of Ohio, Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period, (Aug. 16, 2018) https://ohioauditor.gov/news/pressreleases/Details/5042.

Kentucky Department for Medicaid Services, Medicaid Pharmacy Pricing: Opening the Black Box 5, 8 (Feb. 19, 2019), https chfs.ky.gov/agencies/ohda/Documents1/CHFS_Medicaid_Pharmacy_Pricing.pdf

Melinda Deslatte, Task Force: Is Louisiana Medicaid Drug Spending Inflated?, U.S. NEWS & WORLD REPORT (Oct. 26, 2017), available at https://www.usnews.com/news/best-states/louisiana/articles/2017-10-26/louisiana-spending-on-medicaid-prescription-drugsquestioned

Robert Langreth, Drug Middlemen Got Hefty Markup in New York, Pharmacy Group Says, BLOOMBERG (Jan. 24, 2019), available at https /www.bloomberg.com/news/articles/2019-01-24/drug-middlemen-got-hefty-markup-in-new-york-pharmacygroup-says.

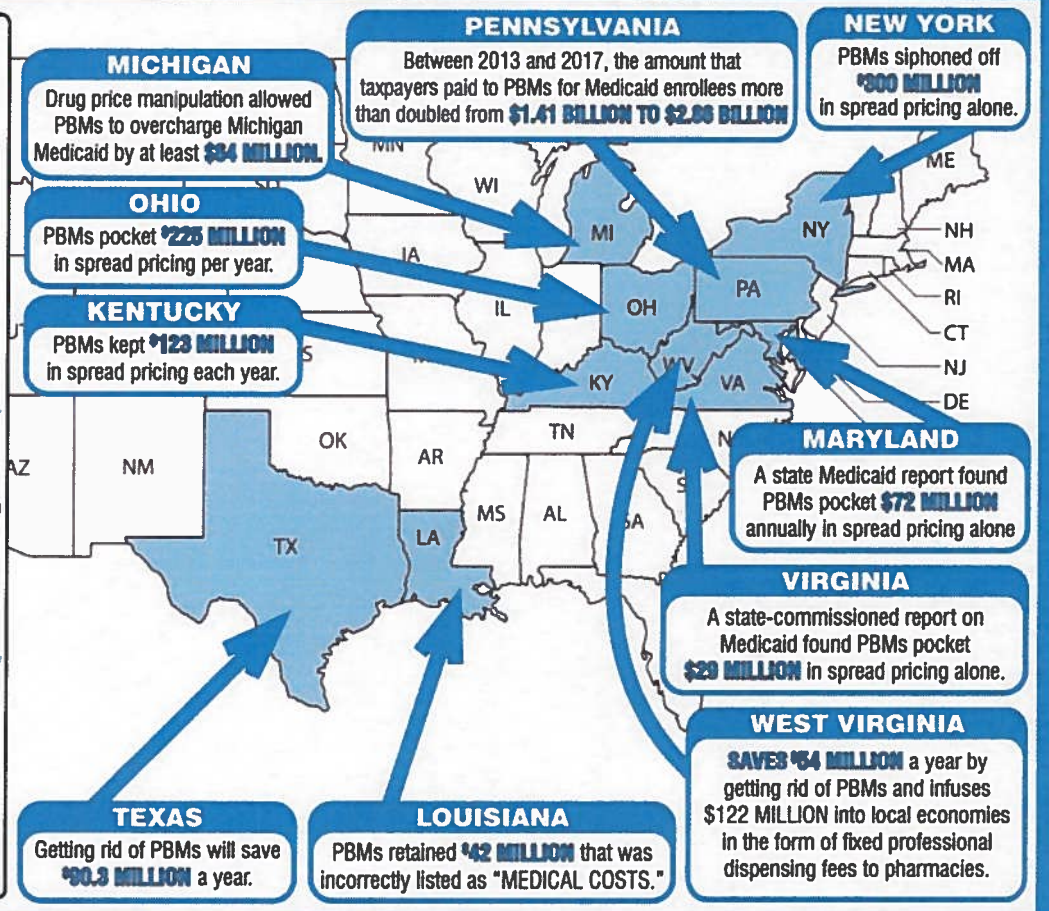
2 Navigant Consulting, Inc., Pharmacy Savings Report: West Virginia Medicaid 5 (2019), available at https dhhr.wv.gov/bms/News/Pages/West-Virginia-Medicaid-Pharmacy-Savings-Report-is-Now-Available!-.aspx. California Executive Department, Exec. Order N-01-19, Rider 60, Final Report on the Study of Potential Cost Savings in the Administration of Prescription Drug

DallasNews.com: https://www.dallasnews.com/news/texas-legislature/2019/03/07/house-bills-aim-save-taxpayers-money-kicking-drug-middlemen-texas-medicaid

Michigan Pharmacists Association, New Report Highlights Role of Pharmacy Benefit Managers in Manipulating Drug Costs for Michigan Patients, Pharmacists, and Taxpayers, (April 29, 2019), available at http://www.michiganpharmacists.org/Portals/0/news/releases/FINAL%20MI%20Report%20Press%20Release.pdf?ver=2019-05-01-110013-603.

Virginia Department of Medical Assistance Services, Managed Care Pharmacy Benefit Manager (PBM) Transaprency Report 3 (Oct. 1, 2019), available at https://rga.lis.virginia.gov/Published/2019/RD593/PDF

Maryland Department of Health, Maryland's 2019 Report on the Maryland Medical Assistance Program and Managed Care Organization that Use Pharmacy Benefits Mangers – Audit and Professional Dispensing Fees 3 (Jan. 3, 2020), available at https· /cdn.ymaws.com/www.marylandpharmacist.org/resource/resmgr/ legislative/mcoauditreport.pdf



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August 21, 2020

Oklahoma Health Care Authority
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RE: SoonerCare Comprehensive Managed Care Program Reference 80720200002

Thank you for giving the Oklahoma Pharmacists Association (OPhA) the opportunity to provide comments on the planned comprehensive Medicaid Managed Care Implementation through the Oklahoma Health Care Authority.

OPhA is the largest community pharmacy trade association in Oklahoma representing over 400 community pharmacies in the state. Our mission is to reinforce the role of pharmacists as essential members of the healthcare team. Last year, the State's pharmacists dispensed nearly 45 million prescriptions to Oklahomans. Beyond that, Oklahoma's pharmacists helped alleviate a critical gap in access to healthcare. For many Oklahomans, their local pharmacy serves as the most convenient-and sometimes only-means to access the health system. In fact, data from the National Survey of Children's Health (NSCH), which measures the share of children who receive coordinated, ongoing, comprehensive care within a medical home indicated only 45.6% of children in Oklahoma have a medical home.[1]

The State's pharmacists have played a crucial role in both preventive and diagnostic medicine, particularly for pediatric and elderly patients. They often serve as an invaluable resource for patients who cannot and have not yet been able to consult with a physician. As an example, the

[1] Kaiser Family Foundation, State Health Facts, Percent of Children with a Medical Home available at: https://www.kff.org/other/state-indicator/children-with-a-medical-home/?activeTab=map&currentTimeframe=0&selectedDistributions=medical-home&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

parent of a sick child may seek advice from a pharmacist on the use of over-the-counter medication before a pediatrician is available.

Pharmacists in Oklahoma are authorized, trained and licensed to administer vaccines and other medications, with no age restrictions, and they perform tests for cholesterol, blood glucose, the flu, streptococcus, and COVID-19. Patients often seek their advice on matters that profoundly affect the public health from quitting smoking to managing diabetes.

OPhA understands that pharmacy costs are one of the fastest growing budget items in the Medicaid budget. In order to contain costs, OPhA would strongly urge the Oklahoma Health Care Authority to carve pharmacy benefits out of the Medicaid managed care program and continue to administer the benefit through the current fee-for-service program.

Continuing pharmacy drug coverage as fee-for-service Medicaid will allow Oklahoma to continue having transparency in its Medicaid program which increases accountability. It will ensure competitive reimbursements, improve health outcomes, and increase access to care all of which will result in cost savings for Oklahoma taxpayers.

Managing the Medicaid prescription drug benefit and pharmacy expenditures is a priority for most states. States have been given much flexibility in administering their Medicaid prescription drug programs. Many states through managed care have relied on a pharmacy benefit manager (PBM) to manage the prescription drug program. The complexity of prescription drug pricing and the lack of transparency by PBMs have created opportunities for PBMs to pocket profits that they should be giving to the state. Promised savings by PBMs have never come to fruition while the PBMs profits have soared. All over the country, community pharmacists' role in the Medicaid program is being threatened by opaque business practices, such as spread pricing, and lack of proper oversight. Even the Centers for Medicare and Medicaid Services is concerned that PBMs' use of spread pricing is inflating prescription drug costs that are borne by the taxpayer.[2] The PBM tactics have decreased reimbursement rates to such a degree that pharmacies are frequently reimbursed at rates that leave them underwater for the drugs they dispense.

Eventually, this leads to pharmacies closing and vulnerable patients left without viable healthcare. A study by the Rural Policy Research Institute found that under-reimbursement led

[2] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers, (May 15, 2019) available at https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not

to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities nationwide that had a least one retail pharmacy in 2003 had **zero** retail pharmacies in 2018. [3] The situation is no better in urban areas; between 2009 and 2015, 1 in 8 pharmacies closed as a result of under reimbursements in the Medicaid and Medicare programs, disproportionately affecting independent pharmacies and low-income neighborhoods.[4] These pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[5]

Administering drug coverage through Medicaid managed care allows PBMs to utilize abusive practices that increase costs for taxpayers.

Not only do opaque PBM practices negatively impact patients and community pharmacies, they also contribute to ever-increasing prescription drug costs for plan sponsors and taxpayers. While discussing PBMs' use of spread pricing, CMS Administrator Seema Verma acknowledged that she was "concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers."[6] The State of New York also investigated PBMs and found "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[7]

Pennsylvania found that between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion. The Pennsylvania Auditor General determined that PBMs were getting perverse incentives and that they needed to pass legislation allowing for a full-scale review. They encouraged the State to directly manage its Medicaid prescription drug benefits instead of contracting with a managed care organization to do so. [8]

In Ohio the State Auditor found that PBMs pocketed more than $224.8 million in spread pricing in one-year period. The PBMs charged the state a spread of more than 31 percent for generic drugs- nearly four times as much as the previously reported average. Ohio audit data confirmed

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[3] Abiodun Salako, Fred Ullrich & Keith Mueller, Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, available at https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf

[4] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, Assessment of Pharmacy Closures in the Unites States from 2009 through 2015, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com

[5] *Id.*

[6] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are no Up-Charging Taxpayers, (May 15, 2019), available at https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not

[7] New York Senate Committee on Investigations and Government Operations, Final Investigative Report: Pharmacy Benefit Managers in New York (May 31, 2019, available at https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf

[8] Pennsylvania Auditor General, Bringing Transparency & Accountability to Drug Pricing 6 (Dec. 11, 2018), available at https://www.paauditor.gov/Media/Default/Reports/RPT_PBM_rebates_022819_final.pdf

that cuts in pharmacy reimbursements from Medicaid PBMs resulted in a loss of 371 pharmacies since 2013, with a majority of the closures occurring from 2016 to present. [9]

According to 46brooklyn, based on the data in Auditor Yost's report, this would leave an average Ohio pharmacy with a margin of only $1.15 per prescription. [10] The most recent Ohio cost of dispensing survey (conducted in 2016) arrived at an average cost to dispense of $10.49 per prescription. [11] Auditors found that most of the financial information related to the relationships between pharmacies and the PBMs are considered proprietary and confidential and thus information was never shared with the state or with its legislators.

Auditors recommended that the State engage an independent third party to conduct a complete analysis of the impact of moving pharmacy services to a fee-for-service model similar to the change implemented in West Virginia.[12]

Complaints in Illinois were similar to those made in other states.[13] A 60 Minutes story about Rockford, Illinois illustrated the core problem with these opaque PBM practices. Rockford paid the health care costs for its city employees, and the mayor noticed a severe spike in the town's drug bill. After investigating the cause of the spike, the mayor realized the town's PBM was part of the cause, and the town sued the PBM for failing to control costs; after all, that is the PBM's job. However, the PBM argued that it was not contractually obligated to control costs![14] Even though plan sponsors are drawn to PBMs because of claims that they control drug costs, **PBMs have no statutory, contractual, or fiduciary obligation to control those costs.**

This is important information for states that run publicly funded health benefit programs, such as Medicaid. Your PBM is under no obligation to control the costs of those programs. Your PBM has no fiduciary duty to taxpayers. The obligation to control costs rests with the elected and other government officials. For this reason, Congress has introduced and is currently considering legislation prohibiting PBMs from using spread pricing in Medicaid managed care programs.[15]

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[9] Auditor of the State of Ohio, Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period, (Aug.16,2018) https://ohioauditor.gov/news/pressreleases/Details/5042

[10] Bloomberg Puts Drug Price "Markups" on the Map (Sept.13, 2018) https://www.46brooklyn.com/research/2018/9/13/bloomberg-puts-drug-price-markups-on-the-map

[11] https://pharmacy.medicaid.ohio.gov/sites/default/files/oh-pdfs-2016-report.pdf

[12] Auditor of the State of Ohio, Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period, (Aug.16,2018) https://ohioauditor.gov/news/pressreleases/Details/5042

[12] Bloomberg Puts Drug Price "Markups" on the Map (Sept.13, 2018)

[13] Dean Olsen, (2018) 'Medicaid managed-care reboot pinching pharmacies, advocates say' *The State Journal-Register, (Apr 29, 2018) available at https://www.sj-r.com/news/20180429/medicaid-managed-care-reboot-pinching-pharmacies-advocates-say*

[14] 60 Minutes, https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/.

[15] Prescription Drug Pricing Reduction Act of 2010, S. 2543, 116th Cong.§206 (2019).

In response to a state report in Kentucky it was found that PBMs kept $123.5 million in spread annually, therefore their Attorney General has launched an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.[16]

Michigan also backed away from pharmacy benefit managers (PBMs) in their Medicaid program, choosing instead to enable fee for service drug payments billed to Michigan's health department through a single, state-contracted PBM.[17]

On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 (EO-N-01-19) for achieving cost-savings for drug purchases made by the state. A key component of EO N-01-19 requires the Department of Health Care Services (DHCS) transition all Medi-Cal pharmacy services from managed care (MC) to fee for service (FFS) by January 1, 2021. They believe that this will standardize the delivery system, improve access to pharmacy services and strengthen the state's ability to negotiate drug rebates.[18]

In Louisiana PBMs retained $42 million that was incorrectly listed as "medical costs. "When the state chooses to do business with profit-driven entities, great effort should be made to ensure that money is not wasted," task force leaders wrote to Jen Steele, Louisiana's Medicaid director.[19]

A state Medicaid report in Maryland also found PBMs pocketing $72 million annually in spread pricing alone.[20]

Florida's MCOs and their PBMs own pharmacies that service Medicaid beneficiaries. A recent study found that PBMs have utilized practices that increase the profitability of these "affiliated pharmacies" at taxpayer expense. In fact, "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."[21]

States have successfully protected taxpayer dollars by transitioning drug coverage to fee-for-service Medicaid

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[16]Kentucky Department of Medicaid Services, Medicaid Pharmacy Pricing: Opening the Black Box 5, 8 (Feb. 19, 2019), https://drive.google.com/file/d/1f0eZyVg5e-lmUOS4VQhQLQHfsVId_XEL/view
Kentucky Attorney General, Beshear Launches Investigation into inflated Prescription Drug Prices, (Mar. 21, 2019) https://kentucky.gov/Pages/Activity-stream.aspx?n=AttorneyGeneral&prid=739

[17] New Report Highlights Role of Pharmacy Benefit Managers in Manipulating Drug Costs for Michigan Patients, Pharmacists and Taxpayers Published: Apr 29, 2019 available at https://www.biospace.com/article/releases/new-report-highlights-role-of-pharmacy-benefit-managers-in-manipulating-drug-costs-for-michigan-patients-pharmacists-and-taxpayers/

[18] Medi-Cal Rx: Transition https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx

[19] Task force: Is Louisiana Medicaid drug spending inflated? Melinda Deslatte, The Associated Press (Oct 6, 2017) https://www.houmatoday.com/news/20171026/task-force-is-louisiana-medicaid-drug-spending-inflated

[20]https://cdn.ymaws.com/www.marylandpharmacist.org/resource/resmgr/legislative/mcoauditreport.pdf

[21] Florida Agency for Health Care Administration, Florida Managed Medical Assistance Program: Extension Request Public Notice Document 4 (June 2020), https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/1115_MMA_Waiver_Extension_Request_Public_Notice_Document_Final_2020-24.pdf

In 2017, West Virginia carved pharmacy benefits out of its Medicaid managed care program and now administers the pharmacy benefits through the more transparent fee-for-service program. This decision not only saved West Virginia over $54.4 million in one year, but also increased reimbursements for the pharmacy community, benefitting patients, taxpayers, and local economies in the state. Based on their own numbers, West Virginia saved, on administrative costs, about $6.41 per claim after they carved the pharmacy benefit out of their Medicaid managed care program.[22] West Virginia's experience highlights the fact that transparency and competitive pharmacy reimbursements are both essential to controlling drug costs. Congress is also looking to increase transparency by requiring Medicaid managed care pharmacy reimbursements to be based on NADAC plus a professional dispensing fee.[23]

Benefits Provided Through MCO's

How can MCO's improve access to evidence-based behavioral health care such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

Pharmacists' services have grown well beyond functions tied only to dispensing medications. Many pharmacists also provide such advanced patient-centered services as coordination of medications during care transitions, medication management, comprehensive medication reviews with ongoing medication monitoring, chronic disease management, disease education, prevention and wellness services, and patient education.

Many of our Oklahoma pharmacists are certified under Mental Health First Aid. This is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. Pharmacist intervention is not a substitute for medical care, diagnosis or treatment but it is a valuable screening tool that many of our pharmacists are now certified to do.

Improving quality of life and health outcomes in a cost-effective manner are important goals of the evolving health care system. Pharmacists are the most accessible health care provider and they have already established levels of trust with their patients. They have access to medical information, i.e. drug lists and they have established relationships with mental health providers. They are the most over-trained and under utilized health care professional in America. SoonerCare should work with pharmacy and utilize them to their benefit. Even marginal improvements would result in substantial savings for the state.

Provider Payments and Services

Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished?

[22] Navigant Consulting, Inc., Pharmacy Savings Report: West Virginia Medicaid 5 (2019), available at https://dhhr.wv.gov/bms/News/Pages/West-Virginia-Medicaid-Pharmacy-Savings-Report-is-Now-Available!-.aspx
[23] Prescription Drug Pricing Reduction Act of 2019, S. 2543, 116th Cong. § 206 (2019)

Require PBMs in the Medicaid managed care program to reimburse pharmacies at fee-for-service rates

As shown by Iowa, Kansas, Louisiana, Mississippi, Arkansas and North Carolina, state Medicaid programs have the authority to ensure reasonable contract terms between MCOs/PBMs and community pharmacies - for example, competitive reimbursement rates.

These states know how their tax dollars are being spent because they established the reimbursement rates for pharmacy services in their Medicaid managed care programs. In those states, PBMs must reimburse pharmacies at the same rates established under the fee-for-service program. [24]

States have found that increasing transparency and providing competitive pharmacy reimbursements, based on NADAC plus a professional dispensing fee, are not antithetical to controlling drug costs. In fact, transparency and competitive reimbursements are vital components of controlling costs. Therefore, OPhA recommends that pharmacies be paid NADAC plus a professional dispensing fee.

Network Adequacy

"What are reasonable time and distance standards in Oklahoma by provider type?"

According to United Health Foundation's latest rankings Oklahoma fell from number 43 to 47th as least healthy state.[25] County Health Rankings and Roadmaps (CHR&R) a Robert Wood Johnson Foundation program found that Oklahoma has the fifth fewest doctors according to a primary care doctor to population ratio.[26] Pharmacy is often the only access to care that a patient has in our state. As the most accessible healthcare provider in our communities pharmacists are critical for providing immunizations and other preventive care services. They have more interaction with the patient and they impact outcomes for a variety of disease states such as chronic asthma, diabetes, mental health, tobacco cessation, pain management, dental health, etc. Access to these services and prescription medications play a critical role in managing chronic conditions which prevent hospitalizations and further costs downstream. These are interactions that cannot be achieved through mail order.

PBM's should be required to follow the access standards similar to those found in HB 2632. [27] The language in HB 2632 provides standards on access benchmarks so that the health insurer networks meet minimum levels of geographic access for beneficiaries within a plan's service area. This prevents plans from establishing differentials between cost sharing at preferred versus non-preferred pharmacies that is often so significant that it discourages beneficiaries from using their local pharmacy. This language is similar to that found in CMS rules for standard pharmacy

[24] Iowa Department of Human Services, Informational Letter No. 1627-MC, (Mar.14, 2016); Louisiana Department of Health, Provider & Plan Resources: Frequently Asked Questions,
[25] United Health Foundation located at: https://www.americashealthrankings.org/learn/reports/2018-annual-report/findings-state-rankings
[26] Robert Wood Foundation Program located at: https://www.countyhealthrankings.org/reports/state-reports
[27] http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/hB/HB2632%20ENR.PDF

networks and ensures that patients have access to pharmacies in their community. Mail order should be excluded when determining access and patients should not be allowed to be steered or forced to use a pharmacy that is vertically integrated or owned by a PBM.

There are three national PBMs in the United States that are responsible for administering 85-90% of the pharmaceutical drugs that are reimbursed by the payors.[28] All three of these PBMs own their own retail pharmacies. Consequently, there is incentive for each of these PBMs to steer patients to use their own pharmacies and to exclude independent pharmacies from their network. Further, given the size of these PBMs, they can leverage unfavorable contract terms with independent pharmacies. Most of the independent pharmacies are located in rural areas of Oklahoma. Excluding them from a network of retail pharmacies providing pharmaceutical benefits to patients in the rural areas not only adversely impacts the independent pharmacies who are excluded but necessitates that patients travel long distances to purchase necessary medications.

Administrative Requirements

"How can MCO's help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?"

The most effective method for MCO's to detect fraud is by audit. However, it has been our experience that the audit process is frequently abused by middlemen generating profits by recouping payments over technical issues that have no bearing on fraud or abuse. If MCO's use an audit they should be done in a safe and fair manner, keeping all pharmacies on an even playing field. Pharmacies should be given adequate time to respond to an audit. MCO's should not be eligible to recoup funds prior to the finalization of the audit or recoup dispensing fees if the medication was never dispensed since the pharmacy never received a fee.

Audits should be conducted in strict compliance with 59 O.S. § 356 et seq. along with the amendments found in HB 2314 (2020)[29]. Even though this bill was not passed due to COVID, it emphasizes the issues that Oklahoma pharmacists have with audits conducted by PBMs. There is little to no recourse for pharmacies and audits have allowed PBMs to assess unreasonable fees to the determent of the patient and the pharmacy.

PBMs should also be required to report all financial and business relationship information regarding their interactions with MCOs and Oklahoma enrolled pharmacies. They should not be shielded by claiming data is proprietary.

[28] CVS, Express Scripts, and the Evolution of the PBM Business Model, Drug Channels (May 29, 2019) https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html

[29] http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENGR/hB/HB2314%20ENGR.PDF

OPhA appreciates the opportunity to share our comments and suggestions with you on your efforts to increase accountability and transparency in the SoonerCare Medicaid program. If you have any questions about the information in these comments, please do not hesitate to contact me.

Respectfully submitted,

Debra Billingsley
Executive Director

August 17, 2020

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

via email: Procurement@okhca.org

Reference 80720200002

Dear Oklahoma Health Care Authority:

The Oklahoma Transit Association (OTA) is the organization representing the public transit providers in rural, urban and tribal areas across the state. We represent the key link in coordinating transportation for health care access using well maintained vehicles and professionally trained and vetted drivers across the state.

We understand that the Oklahoma Health Care Authority (OHCA) is preparing to seek proposals from qualified managed care organizations (MCOs) with goals to improve health outcomes, increase access to care, and increase system accountability in the Medicaid program (SoonerCare). We are writing this letter in reference to OHCA's request for stakeholder input prior to finalizing the RFP.

Increase Access to Care
It is the "increase access to care" goal that is most important to public transit providers. Our focus is on the SoonerRide Non-Emergency Medical Transportation (NEMT) program and how it can best serve SoonerCare, MCOs and the Medicaid clients. OTA is committed to ensuring that SoonerRide service is held to the high standards the state's vulnerable population deserves.

In the push for lower costs for transportation, safety and quality cannot be sacrificed. We believe that there does not need to be a choice between cost control and quality. Professional transit systems can achieve low costs while ensuring the safety of the riders, and there are modifications that do need to be made to the existing SoonerRide transportation program to ensure both.

Coordinating Service and Eliminating Duplication
If there are multiple MCOs in an area, the key decision is should the SoonerRide service be "carved into" MCO contracts or "carved out". "Carve out" is the key if there are multiple providers – let one entity experienced in transit handle transportation on a coordinated basis. Oklahoma and SoonerCare are best served by having one transportation broker in each region or statewide. Having each MCO be responsible for transportation of just

their clients ("carved in") will result in significant duplication of service, lower quality and less safety assurances, and will cost considerably more for service as multiple organizations are providing transportation in an uncoordinated manner.

"Carved In" Transportation Results in Duplication and Other Problems
Our primary concern is for OHCA to avoid the "carved in" approach to SoonerRide where each MCO contracts with its own broker. This will require multiple transportation programs for one area and a significant degradation of service, particularly in rural areas.

1. **Significant duplication** – Costs go up as there are multiple transportation programs, multiple call centers, managers and staff all duplicating what the other is doing. It will result in three or four vans from different MCO transportation programs arriving at a hospital with one patient each, rather than one van with three to four patients from any MCO, tripling the costs of service.

2. **Creates confusion among health care providers** – Providers may have four to six different brokers to call depending on the MCO.

3. **Monitoring each MCO transportation service –** With the extensive number of brokers and providers it will be difficult to monitor and oversee the various brokers and operators.

4. **Reduction in safety and service quality** – Safety is the number one priority. By allowing SoonerRide service to operate far below the appropriate standards of safety and professionalism, as was cited in a General Accounting Office review of SoonerRide, clients are put at risk.

The Solution: Safety and Service Quality
SoonerCare has an opportunity to improve access to health care and allow the MCOs to focus on what they do best – health care, while allowing transit to do what it does best – take people to health care appointments in a safe and reliable manner. OTA welcomes the opportunity to explore the options for SoonerRide with OHCA. Following are our recommendations to make SoonerRide and transit a Top Ten NEMT program.

1. **"Carve Out" Transportation: One transportation broker per region or statewide** will eliminate duplication and ensure coordination of service. We realize that this will require an additional procurement, but it would be well worth the effort in safety alone. The possibility of having six separate brokerages in Tulsa or Oklahoma City is a nightmare scenario for the MCOs and transit.

2. **Let the transit professionals manage the transportation**. MCOs should not have to oversee transportation programs. That work is best left to the Oklahoma transit operators or equivalent professional transportation management team.

3. **A need to level the playing field** – SoonerRide has been plagued with problems of non-public transit untrained drivers in its brokerage. Untrained drivers are a cardinal sin in transportation and coupled

with a lack of driver oversight and low standards, will result in significant problems. OTA suggests the following for safety and lower costs:

a. This starts with the RFP to procure services. Driver and vehicle standards should be equal to public transit system standards. The ridership is very vulnerable and alone with these drivers.

b. The current SoonerRide structure does not allow the broker to identify who is actually driving when non-public transit vehicles are used. There should be a requirement that the broker be able to verify the identity of every driver and vehicle on the road to ensure the designated person is doing the driving.

c. SoonerRide should only allow for well-trained drivers, safe vehicles and drivers that are actually monitored and supervised during the day.

d. By coordinating services and improving service productivity – while meeting public transit's stringent standards – the transportation costs can be kept low.

A Top Ten State
We believe in the Governor's mission to make Oklahoma a Top Ten state. We welcome the opportunity to work with and/or partner with OHCA to provide the safest and most affordable service for those most in need.

By deploying these recommendations SoonerRide will be:

- Safer;
- More responsive to the client's needs; and
- Provided at a lower cost due to higher productivity and elimination of duplicative service found in the "carved in" service model.

Sincerely,

Mark C. Nestlen
Executive Director

August 17, 2020

Submitted via: Procurement@okhca.org

Melody Anthony
Medicaid Director
Oklahoma Health Care Authority
Federal Authorities Unit,
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design (80720200002)

Dear Director Anthony,

ViiV Healthcare Company (ViiV) appreciates the opportunity to submit comments to The Oklahoma Health Care Authority (OHCA) regarding the State of Oklahoma's Request for Public Feedback in Program Design of a SoonerCare Comprehensive Managed Care Program (RFPF).[1]

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people living with HIV (PLWH). From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help PLWH to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[2,3] Furthermore, effective HIV treatment can also prevent the transmission of the disease.[4]

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[1] Oklahoma Health Care Authority "SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design" http://okhca.org/mco/ Accessed August 10, 2020

[2] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201.

[3] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714.

[4] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 https://dx.doi.org/10.1016/S0140-6736(19)30418-0.

PLWH and Oklahoma's Proposal to Implement Managed Care

Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for people living with HIV.[5] Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of PLWH are retained in medical care, according to the Centers for Disease Control and Prevention (CDC).[6]

It is imperative that traditional Medicaid and Medicaid Managed Care Organizations (MMCOs) work to expand access to HIV prevention, to preserve continuous access to comprehensive high-quality health care, including antiretroviral therapy (ART) for people with HIV in order to improve health outcomes and reduce new transmissions.

ViiV applauds the State of Oklahoma for expanding Medicaid services. As the state intends to manage the expansion population through managed care, we wish to provide direction on important considerations for PLWH in managed care, and examples from other states that may help to inform Oklahoma's efforts.

1. The "Ending the HIV Epidemic (EHE) Initiative" and Medicaid

In 2019, President Trump announced his Administration's goal to end the HIV epidemic in the U.S. within 10 years and released the "Ending the HIV Epidemic: A Plan for America." [7] This plan proposes to use scientific advances in antiretroviral therapy to treat PLWH and expand proven models of effective HIV care and prevention. The plan also focuses its efforts to stop the HIV epidemic across government agencies.

Oklahoma is one of seven states targeted by the EHE initiative for its high rates of new HIV infections.[8] According to the CDC, there were approximately 5,926 people living with HIV in Oklahoma in 2016, and 302 people were newly diagnosed with HIV in 2017.[9] In 2019, the U.S. Department of Health and Human Services (HHS), through the CDC, awarded Oklahoma $375,000 to conduct state and local planning and kick off community involvement for the EHE initiative.[10] In 2020, Oklahoma received a second funding award under the EHE initiative of $1,808,416 to health centers in Tulsa and Oklahoma City and the state's Ryan White HIV/AIDS Program.[11,12,13]

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[5] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
[6] Understanding the HIV Care Continuum, CDC, https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf Accessed June 19, 2019.
[7] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview Accessed July, 15, 2019.
[8]Ending the HIV Epidemic Counties and Territories, https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf Accessed March 12, 2020.
[9] AIDS Vu: Oklahoma https://aidsvu.org/local-data/united-states/south/oklahoma/ Accessed March 31, 2020.
[10] HHS.gov, "HHS Awards $13.5 Million to Accelerate State and Local Planning Efforts for Ending the HIV Epidemic: A Plan for America" Press Release, October 2, 2019. https://www.hhs.gov/about/news/2019/10/02/hhs-awards-13.5-million-dollars-to-accelerate-state-and-local-planning-efforts.html Accessed March 31,2020.
[11] Bureau of Primary Health Care, HRSA.gov, "FY 2020 Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Awards," https://bphc.hrsa.gov/program-opportunities/primary-care-hiv-prevention/fy2020-awards Accessed March 31,2020.
[12] HIV/AIDS Bureau, HRSA.gov, "FY 2020 Ending the HIV Epidemic Awards" https://hab.hrsa.gov/about-ryan-white-hivaids-program/fy2020-ending-hiv-epidemic-awards Accessed March 31,2020.
[13] "Oklahoma awarded more than $1.8 million to fight HIV," Tim Stanley, Tulsa World, pub Mar 2, 2020 https://www.tulsaworld.com/news/local/oklahoma-awarded-more-than-1-8-million-to-fight-hiv/article_41c27b22-5924-54f1-86f3-220f072faead.html Accessed March 31,2020.

For these reasons, we urge CMS to consider our comments on this waiver proposal in light of the Administration's goals established by the EHE Initiative. As Oklahoma's Medicaid program has a significant role in achieving these goals.

Medicaid is the largest source of coverage for people living with HIV.[14] In fact, more than half of PLWH who are engaged in medical care have incomes at or below the federal poverty level.[15] Medicaid is an essential source of access to medical care and ART drug coverage for people living with HIV. This medical care and drug treatment not only preserves the health and wellness of PLWH and improves health outcomes, but it also prevents new HIV transmissions.

In order to promote the goals of the EHE plan, it is imperative that state Medicaid programs align with local and national efforts to end the HIV epidemic, and promote policies that contribute to HIV public health goals, such as preserving continuous access to comprehensive health care, including ART.

Given the increased portion of Medicaid beneficiaries that are enrolled in managed care, we ask the OHCA to contractually require MMCOs to also support the goals of the EHE, and address the HIV care continuum by providing open access to ART without utilization management, covering pre-exposure prophylaxis (PrEP), and reporting HIV quality measures. MMCOs can also be encouraged to partner with the HIV/AIDS officials within the state's health department to provide information to all providers about HIV, disproportionately impacted populations, LGBTQ health, stigma, and the message of Undetectable = Untransmittable (U=U).

2. PLWH Require Open Access to ART

ViiV supports coverage policies that ensure open access to HIV treatment for all PLWH. Therefore, we encourage OCHA to ensure open access to life-saving treatment for PLWH and access to PrEP for at-risk populations by requiring the MMCOs in the state to maintain open access to all ART on their formularies. This would support the work of the EHE and help to align coverage for ART across all state programs.

More than 1.1 million people in the United States are living with HIV, and just over 14 percent are unaware that they have the virus.[16] Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are changed and updated to reflect advances in medical science. PLWH often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment.

Prescription drug treatment is essential to PLWH, to effectively manage a deadly virus, to extend health and wellness, and to prevent transmission. The clinical standard for HIV treatment is combination ART, and many regimens are available as a once-per-day single tablet regimen (STR). Medical challenges for PLWH also include an increased risk for, and prevalence of, comorbidities that require additional drug treatment such as depression and substance use disorders, as well as cardiovascular disease, hepatic

[14] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/
[15] CDC, Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2014.pdf 2014 cycle (June 2014-May 2015). Surv report 17
[16] HIV in the United States: At a Glance, CDC, https://www.cdc.gov/hiv/statistics/overview/ataglance.html. Accessed June 19, 2019.

and renal disease, osteoporosis, metabolic disorders, and several non–AIDS-defining cancers. [17,18,19,20] The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.[21] Thus, PLWH must have access to a robust formulary that provides physicians with the ability to prescribe the right treatments at the right time for their patients.

HHS stressed the importance of covering all FDA approved drugs, including ART for PLWH, in its December 1, 2016 Informational Bulletin entitled *Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries*:

> Given that adherence to ART is a critical prerequisite to realizing both individual and public health benefits, states are reminded of the statutory requirement to cover all covered outpatient drugs of manufacturers with agreements described in section 1927(b) of the Act, including single tablet ART regimens. States can also, and are strongly encouraged to, go farther to support access and adherence to effective treatments for PLWH. States should design their prescription drug formularies to minimize potential barriers presented by utilization management techniques so that Medicaid and CHIP beneficiaries living with HIV can readily access all regimens described for potential use (including those labeled as "Recommended", "Alternative", and "Other") in the DHHS Guidelines.[22]

Accordingly, it is critical that PLWH in Oklahoma have access to all necessary treatments to optimize their overall health rather than limiting access through a closed formulary. Studies show that restricting access to drugs through closed formularies results in non-adherence or poor adherence to prescribed medication regimens, worsened health outcomes, and higher, long-run costs, both to Medicaid and other state and local programs.[23, 24]

a) ART Must Be Protected from Utilization Management

ViiV is strongly opposed to any proposal which subjects HIV treatments to bureaucratic oversight through utilization management, such as step therapy or prior authorization. We urge the OCHA to prohibit the MMCOs from applying utilization management techniques, such as prior authorization to their coverage for ART.

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[17] CDC. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection. Medical Monitoring Project United States, 2013 Cycle (June 2013–May 2014).HIV Surveillance Report 16.
[18] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518.
[19] Rodriguez-Penney, Alan T. et al. "Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life." AIDS Patient Care and STDs 27.1 (2013): 5–16. PMC. Web. 21 June 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3545369/.
[20] Joint HHS, CMCS, HRSA, and CDC Informational Bulletin, Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, p. 9 (December 1, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf. Accessed October 13, 2017.
[21] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518.
[22] Joint HHS, CMCS, HRSA, and CDC Informational Bulletin, Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, p. 12 (December 1, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf. Accessed October 13, 2017.
[23] Happe LE, Clark D, Holliday E, Young T. A systematic literature review assessing the directional impact of managed care formulary restrictions on medication adherence, clinical outcomes, economic outcomes, and health care resource utilization. J Manag Care Spec Pharm. 2014;20(7):677-84.
[24] Zullig, LL, Bosworth, H, Engaging patients to optimize medication adherence. NEJM Catalyst, May 14, 2017.

Due to the individualized nature of HIV treatment, it is important that treatment decisions not be subject to management processes which run the risk of disrupting established treatment regimens. A review of 29 studies evaluating the impact of non-medical switching (the practice of switching to a chemically distinct but similar medicine for reasons other than lack of clinical efficacy/response) found that among patients with stable, well-controlled disease switching led to poor side effects or nonadherence and was associated with mostly negative outcomes.[25]

Prior authorization can lead to patients experiencing delays in receiving their medications, which negatively impacts patient adherence – a vital component of effective HIV treatment. In a study, people living with HIV who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.[26]

Within the Medicare program HIV is a protected class, and ART drugs are not subject to utilization management. The Medicare Prescription Drug Benefit Manual states: "For HIV/AIDS drugs, utilization management tools such as prior authorization and step therapy are generally not employed in widely used, best practice formulary models."[27]

Prior authorization requirements also impact provider efficiency, and increase costs of care.[28, 29] The historic lack of uniformity between health plans' and insurers' prior authorization processes results in providers spending excessive amounts of time completing prior authorization forms, negotiating administrative systems and spending less time on patient care.[30] More importantly, restricting access to HIV treatment for Medicaid beneficiaries may have permanent consequences for future treatment options.

CMS declared support for applying the Medicare Part D protected classes protection for HIV treatment to the Medicaid program in recent guidance:[31]

> In addition, to ensure that this demonstration supports CMS's objectives related to the treatment of HIV… CMS expects states to provide coverage of… substantially all antiretroviral drugs (including PrEP) consistent with Medicare Part D coverage...[32]

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[25] Nguyen E, Weeda E, Sobieraj D, et al. Impact of Non-Medical Switching on Clinical and Economic Outcomes, Resource Utilization and Medication-Taking Behavior: A Systematic Literature Review. *Current Medical Research and Opinion*.2016;32(7):1281-1290. Accessible at: https://www.ncbi.nlm.nih.gov/pubmed/27033747.

[26] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1.

[27] CMS.gov "Prescription Drug Benefit Manual" https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.

[28] Health Affairs "What does it cost physician practices to interact with health insurance plans?" 2009 http://content.healthaffairs.org/content/28/4/w533.abstract?ijkey=ab6e6c7d689c5a4949c03fc849458f04aeb59a2d&keytype2=tf_ipsecsha.

[29] Oxford Journal of Clinical Infectious Diseases "Uncompensated Medical Provider Costs Associated with Prior Authorization for Prescription Medications in an HIV Clinic" Vol. 51 Issue 6, 2010 http://cid.oxfordjournals.org/content/51/6/718.abstract.

[30] Health Affairs "US physician practices versus Canadians: spending nearly four times as much money interacting with payers. 2011. http://content.healthaffairs.org/content/30/8/1443.abstract?ijkey=702ae6e197f5830f7a20cd1ac2a80f693306073f&keytype2=tf_ipsecsha.

[31] Medicaid.gov, SMD# 20-001, Re: Healthy Adult Opportunity SMD, January 30, 2020: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf. Accessed July 8, 2020.

[32] Medicaid.gov, SMD# 20-001, Re: Healthy Adult Opportunity SMD, January 30, 2020 (Page 9): https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf. Accessed July 8, 2020

We hope that Oklahoma will also apply Medicare Part D-like protections to ART access in the MMCOs, by prohibiting utilization management, step therapy, or prior authorization for ART.

b) Importance of Adherence

The state requested comments on appropriate utilization management techniques. ViiV is opposed to any utilization management of ART for PLWH as it can negatively impact adherence and cause viral resistance and lead to loss of effectiveness for an entire therapeutic class to a patient.

Strict adherence to ART – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.[33] The Health Resources and Services Administration (HRSA) states in its *Guide for HIV/AIDS Clinical Care* that "adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival."[34] Nonadherence – or skipping HIV medicines – may lead to drug-resistance, and reduce or eliminate the effectiveness of treatment with some HIV medicines.[35] In fact, the World Health Organization (WHO) recently reported that resistance among people retained on ART ranged from four to 28 percent, while among people with unsuppressed viral load on first-line ART regimens, resistance ranged from 47 to 90 percent.[36] The U.S. Department of Health and Human Services' (DHHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, referred to as the federal HIV clinical treatment guidelines, also emphasizes the importance of adherence to ensure long-term treatment success.[37]

For PLWH, un-interrupted adherence to antiretroviral medication is paramount in maintaining their health, maintaining viral suppression, preventing medical complications and co-morbidities, and preventing new transmissions.

Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. For PLWH, adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities.[38,39] PLWH who face drug benefit design changes are nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance and increased morbidity and mortality.[40] To achieve optimal clinical outcomes for PLWH and to realize the potential public health benefit of treatment as prevention, adherence to ART and retention in care are essential. The DHHS HIV

[33] AIDS info.gov, NIH, Following an HIV Regimen: Steps to Take Before and After Starting HIV Medicines, January 31, 2019 https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/55/following-an-hiv-regimen---steps-to-take-before-and-after-starting-hiv-medicines.
[34] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.
[35] AIDS Info, HIV Treatment Fact Sheet (March 2, 2017), https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance. Accessed October 13, 2017.
[36] WHO, HIV Drug Resistance Report 2017, http://apps.who.int/iris/bitstream/10665/255896/1/9789241512831-eng.pdf?ua=1. Accessed October 13, 2017.
[37] DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, NIH.gov https://aidsinfo.nih.gov/guidelines. Accessed on 6/26/2019.
[38] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.
[39] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.
[40] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1.

Treatment Guidelines state, "… high-quality system processes are vital in promoting rapid linkage and sustained retention in care and adherence to ART."[41]

Oklahoma already provides protections for ART by prohibiting the DURB from applying prior authorization to any HIV therapies for treatment or prevention of ART in its traditional Medicaid program.[42] We urge the state to extend this protection into the MMCO formularies as well.

For one example in applying these concepts to MMCOs, the OHCA could refer states to use the Mississippi DURB study[43] as one model for how FFS and MMCOs should look at HIV adherence. CMS could also suggest that states require that MMCOs put an adherence program in place to assist providers who have patients who are under 90 percent adherence.

c) HIV Treatment as Prevention

When a PLWH receives and maintains effective HIV treatment and receives quality medical care they can reach viral suppression. Viral suppression means that the virus has been reduced to an undetectable level in the body with standard tests.[44] Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.[45]

Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy, there were no linked infections observed when the HIV+ partner's HIV viral load was below the limit of detection.[46] The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when PLWH achieve and maintain viral suppression, there is no risk scientifically of transmitting HIV to their HIV-negative sexual partner.[47] Multiple subsequent studies also showed that PLWH on ART who had undetectable HIV levels in their blood, had essentially no risk of passing the virus on to their HIV-negative partners sexually.[48, 49, 50] As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.[51]

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[41] DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, NIH.gov https://aidsinfo.nih.gov/guidelines. Accessed on 6/26/2019.
[42] 2014 Oklahoma Statutes Title 63. Public Health and Safety §63-5030.5. Drug prior authorization program - Conditions**:** https://law.justia.com/codes/oklahoma/2014/title-63/section-63-5030.5/
[43] Antiretroviral adherence in the treatment of HIV" -- Special Analysis Project presented to the Mississippi Division of Medicaid Drug Utilization Review Board, March 19, 2020. https://medicaid.ms.gov/wp-content/uploads/2020/03/DURAgenda031920.pdf Accessed on April 8, 2020, page 30.
[44] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.
[45] "Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions," Stricker, et al, AIDS and Behavior, October 2014, Volume 18, Supplement 5, pp 465–47,: https://link.springer.com/article/10.1007/s10461-013-0598-6
[46] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0 .
[47] NIAID, https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable. Accessed August 1, 2018.
[48] Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. BMC Public Health. 2014; 14: 917. doi: 10.1186/1471-2458-14-917.
[49] Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. N Engl J Med 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693.
[50] "HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention" National Institute of Allergy and Infectious Diseases https://www.niaid.nih.gov/diseases-conditions/treatment-prevention.
[51] Centers for Disease Control and Prevention (CDC) "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html Accessed September 20, 2019.

Reduced transmissions not only improve public health, but also save money. Preventing new transmissions offers a substantial fiscal benefit to the state. In studies sponsored by the NIH, investigators have shown that when treating the HIV-positive partner with antiretroviral therapy,[52] there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[53] Other studies estimate that each HIV positive patient may approach $338,400 in additional costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.[54] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $1.79 million by preventing[55] further transmission to others. These savings can only occur, access to medical care, receive treatment, and remain adherent to their prescribed therapy.

ViiV encourages OHCA to promote this separate but dual benefit of HIV "treatment as prevention" (TasP)[56] to all MMCOs, and provide education that the fact that achieving and maintaining viral suppression for PLWH can also prevent new infections.

d) Importance of HIV Pre-exposure prophylaxis (PrEP) Coverage

ViiV supports coverage of pre-exposure prophylaxis (PrEP) to all at-risk populations. ViiV encourages OCHA to require MMCOs to support the goals of the EHE initiative by covering PrEP for all beneficiaries.

Use of PrEP by at-risk populations is a key part of the EHE. The "Ready, Set, PrEP!" Initiative,[57] could be further advanced by state Medicaid programs.

Additionally, the US Preventive Services Taskforce (USPSTF) recently issued a "Grade A" rating of HIV PrEP treatment.[58] The new USPSTF recommendation means that Medicaid programs that cover PrEP without cost-sharing along with other preventive services can receive an FMAP increase under the ACA, similar to coverage of HIV testing.

[52] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0.
[53] Skarbinski, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. *JAMA Intern Med*. 2015;175(4):588-596.
[54] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/.
[55] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/.
[56] HIV.gov, For HIV, Treatment is Prevention, https://www.hiv.gov/blog/hiv-treatment-prevention
[57] "Ready, Set, PrEP" HIV.gov, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/prep-program
[58] US Preventive Services Task Force Final Recommendation Statement, "Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis," June 11, 2019
https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/prevention-of-humanimmunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis

3. Provider Network Adequacy for PLWH

Access to qualified medical care providers is important for PLWH in order to monitor disease progression and ensure viral suppression is maintained.[59,60] Access to infectious disease specialists and HIV-specialized providers[61] is vital for PLWH, as HIV patients see better outcomes when treated by an experienced HIV provider.[62]

Since the beginning of the HIV epidemic, providers from a variety of specialties (such as Infectious Disease Specialists and family medicine) and licensures (physician's assistants, nurses, nurse practitioners) have focused in HIV care and treatment and served this vulnerable population. There is no board certification for HIV medicine, but several professional organizations have identified criteria for designation of HIV specialists, [63] and some states have also codified HIV specialty.[64]

PLWH depend on access to experienced medical providers with HIV expertise for effective management of their disease. Individuals with HIV whose care is managed by an experienced HIV medical provider are more likely to be retained in care, virally suppressed, and to receive more cost-effective care.[65] [66]

The importance of continuity of care for medically underserved patients, particularly people living with HIV, is significant. Patients retained in active medical care often have long-standing, trusting relationships with their medical provider, which is a key piece of the successful management of HIV. Exclusion of these providers from coverage networks can lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations. Achieving control of the virus requires regular access to a medical provider. Gaps in HIV treatment of days to weeks can reverse viral suppression, increase risk of transmission to others, and lead to serious complications, including development of a virus that is drug resistant, and more difficult to treat.[67]

For these reasons, we would encourage the OCHA to require that the MMCOs contract with all available HIV providers in the state and to allow PLWH to maintain access to their current HIV care management providers.

We also offer the following suggestions around provider requirements for the new MMCOs:

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[59] Kitahata MM, Koepsell TD, Deyo RA, Maxwell CL, Dodge WT, Wagner EH. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. New Engl J Med. 1996;334:701–7. [PubMed]
[60] Gallant, Joel E. et al. "Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition." Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America53.11 (2011): 1043–1050. PMC. Web. 20 Dec. 2017.
[61] Identifying Providers Qualified to Manage the Longitudinal Treatment of Patients with HIV Infection and Resources to Support Quality HIV Care Revised: March 2013, HIV Medicine Association https://www.hivma.org/globalassets/hivma/logos/revised-qualified-hiv-provider-policy-statement-approved-3-16-13-1.pdf.
[62] Gallant, et al. Essential Components of Effective HIV Care. *Clinical Infectious Diseases*. 2011 Dec; 53(11):1043-50
[63] HIV Medicine Association (HIVMA), American Academy of HIV Medicine (AAHIVM), and Associations of Nurses in AIDS Care (ANAC). The AAHIVM has a credentialing process for HIV physicians, nurse practitioners, physician's assistants and pharmacists. ANAC created the HIV/AIDS Nursing Certification Board for certification of registered nurses and nurse practitioners in HIV nursing.
[64] Florida Agency for Healthcare Administration, Medicaid Managed Care Contract, The HIV/AIDS Specialty Plan, Attachment II, Exhibit II-C, HIV/AIDS Specialty Plan, November 1, 2015, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-C-HIV-AIDS_2015-11-01.pdf Accessed July 6, 2020
[65] Kitahata MM, Koepsell TD, Deyo RA, Maxwell CL, Dodge WT, Wagner EH. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. New Engl J Med. 1996;334:701–7. [PubMed]
[66] Gallant, Joel E. et al. "Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition." *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*53.11 (2011): 1043–1050. *PMC*. Web. 20 Dec. 2017.
[67] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf [Discontinuation or Interruption of Antiretroviral Therapy].

a) Include Essential Community Providers in Network

We encourage the state to require MMCOs to contract with all essential care providers in the state, including federally qualified health centers, rural health centers, community health centers, Ryan White clinics, and local health departments.

The Ryan White HIV/AIDS Program provides direct health care and support services for over half a million PLWH— more than 50 percent of all people living with diagnosed HIV in the U.S.[68] Ryan White providers are designated as essential community providers (ECPs) by the federal government because of the role they play in caring for and treating medically underserved and low-income people with HIV/AIDS.[69]

Health care providers that serve a large proportion of low-income or medically underserved individuals are given a designation of "essential community providers" (ECP) under federal law. CMS identifies Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" clinics, Ryan White HIV/AIDS Program Providers, Indian Health Providers, and STD clinics as ECPs among others. Commercial plans in the state exchanges are required to have a sufficient number and geographic distribution of ECPs to ensure access to a broad range of such providers for low-income, medically underserved individuals.[70]

We encourage OCHA to also require the MMCOs in the state to cover access to these same providers, as many of these entities serve PLWH and at-risk populations. Including them in provider networks would further serve to ensure PLWH can stay retained in care with their established provider.

b) Accessibility

We urge the state to require all MMCOs to make current and updated provider directories available in standardized formats and multiple languages, so that beneficiaries and other stakeholders have access to comprehensive information on providers available within a plan.

c) HIV Medical Training Opportunities

We suggest that the state require the MMCOs to provide information about HIV education opportunities to all physicians operating under the state Medicaid program as well as resources for consultation for inexperienced providers treating PLWH.

As mentioned above, Oklahoma is one of seven states targeted by the federal EHE initiative for its high rates of new HIV infections. [71] This indicates a need for increased attention and education on HIV prevention and treatment among providers in the state. Providers in the state

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[68] Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2016 https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf Accessed: 11/29/2017

[69] Kaiser Family Foundation, "Contract Offering and Signing Standards for Essential Community Providers (ECPs) in Marketplaces," 2015 https://www.kff.org/other/state-indicator/contract-offering-and-signing-standards-for-essential-community-providers-ecps-in-marketplaces/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Accessed July 30, 2020.

[70] Kaiser Family Foundation, "Contract Offering and Signing Standards for Essential Community Providers (ECPs) in Marketplaces," 2015, https://www.kff.org/other/state-indicator/contract-offering-and-signing-standards-for-essential-community-providers-ecps-in-marketplaces/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Accessed July 30, 2020

[71] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview Accessed July, 15, 2019.

should be made aware of the HIV education and consultation options offered by the federal government.
The federal Health Resource Services Administration (HRSA), which administers the Ryan White program, offers direct provider-to-provider consultation services through the National HIV/AIDS Clinician Consultation Center, including several hotlines: the "HIV Management Service Warmline," the Post-Exposure Prophylaxis Hotline (PEPline), Perinatal HIV Consultation and Referral Services (Perinatal HIV Hotline), the Pre-Exposure Prophylaxis Service (PrEPline), and the Clinical Substance Use Consultation (Substance Use Warmline). [72]
Additionally, the Ryan White AIDS Education Training Centers (AETCs) are regional bodies which offer resources and program for provider education on HIV.[73] MMCOs should advise network providers on the offerings of the AETCs.

We would like to further encourage the state to require that all providers in the state fulfill a minimum amount of continuing medical education (CME) training on HIV. Due to the high burden of HIV incidence, the District of Columbia requires licensed health professionals to complete at least ten percent of their continuing education in the public health priorities of the District, including HIV[74] and LGBTQ cultural competency to help health care professionals to better understand the health challenges faced by these communities.[75] This is especially important for those providers who treat only a few PLWH, as studies show that HIV patients see better outcomes when treated by an experienced HIV provider.[76]

d) Undetectable = Untransmittable

The scientific breakthrough that HIV treatment also offers the benefit of prevention of HIV transmission led to the development of a movement called "U=U" or Undetectable = Untransmittable. Multiple studies showed that PLWH on ART who have undetectable HIV levels in their blood, have no risk of passing the virus on to their HIV-negative partners sexually.[77,78, 79] As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.[80] Backed by this science , U=U reinforces the message that viral suppression can help end the HIV epidemic.[81]

[72] National Clinician Consultation Center: https://aidsetc.org/aetc-program/national-clinician-consulation-center
[73] HRSA's AIDS Education and Training Center (AETC) Program: https://aidsetc.org/
[74] DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH, PUBLIC NOTICE: IDENTIFYING PUBLIC HEALTH ISSUES FOR CONTINUING EDUCATION, REGISTER VOL. 66 - NO. 45 NOVEMBER 1, 2019
https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/10%25%20CE%20-%20Public%20Notice%20-%2066%20DCR%2014518-14519.pdf
[75] DC.gov Board of Medicine, Continuing Education Requirements, https://dchealth.dc.gov/bomed
[76] Gallant, et al. Essential Components of Effective HIV Care. *Clinical Infectious Diseases*. 2011 Dec; 53(11):1043-50
[77] Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. BMC Public Health. 2014; 14: 917. doi: 10.1186/1471-2458-14-917
[78] Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. N Engl J Med 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693
[79] "HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention" National Institute of Allergy and Infectious Diseases https://www.niaid.nih.gov/diseases-conditions/treatment-prevention
[80] Centers for Disease Control and Prevention (CDC) "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html Accessed September 20, 2019.
[81] NIH.gov "Science Validates Undetectable = Untransmittable HIV Prevention Message" NIAID Now, July 22, 2018 https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable, Accessed 1/14/2020

Today, the NIH, CDC and health authorities in many other countries have endorsed the U=U message.[82, 83] Over twenty states and many more regional health departments have endorsed U=U in a variety of capacities. [84]

The state of Oklahoma has also endorsed the message of U=U.[85] We urge the OCHA to partner with the Oklahoma State Department of Health to provide information to the MMCOs about U=U. Furthermore, we encourage the OCHA to require the MMCOs to provide information and resources about U=U to all providers in their networks. Information is available along with materials[86] on U=U that all Medicaid providers may find useful. This message is an important step in combatting stigma and encouraging PLWH and medical providers to pursue viral suppression as the goal of HIV treatment.

e) Stigma as a Social Determinant of Health

We applaud the state for requiring the MMCOs to engage in Social Determinants of Health strategies, in order to "help members address the root causes of many health issues."[87] We urge the state to collaborate with PLWH and HIV stakeholders to develop strategies that address and combat HIV stigma and LGBTQ stigma as a key social determinant of health.

Stigma is a significant concern in addressing the HIV epidemic.[88, 89, 90] HIV stigma - the negative attitudes or beliefs around HIV disease - can lead to discrimination and prejudice from others, and even by healthcare providers. [91] HIV stigma is often rooted in lack of information and awareness combined with outdated beliefs and scientific misconceptions about how HIV is transmitted and what it means to live with HIV today. According to the CDC, HIV stigma and discrimination can keep people from getting tested for HIV, learning their HIV status, accessing treatment, or staying in care. HIV stigma can also affect those at risk of HIV by discouraging them from seeking HIV prevention tools and testing.[92]

HIV continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities and gay and bisexual men. Populations disproportionately affected by HIV are also often affected by stigma due to, among other things, their gender, sexual orientation, gender identity, race/ethnicity, drug use, or sex work. [93] Therefore, the CDC recommends that, "The

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[82] "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV," CDC, https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html
[83] "For HIV, Treatment is Prevention" Dr. Francis Collins, NIH Director's Blog, posted January 22nd, 2019 https://directorsblog.nih.gov/2019/01/22/for-hiv-treatment-is-prevention/
[84] "UNDETECTABLE = UNTRANSMITTABLE: HEALTH DEPARTMENT ENGAGEMENT MAP" NASTAD, https://www.nastad.org/maps/undetectable-untransmittable-health-department-engagement-map
[85] Oklahoma State Department of Health, U=U Statement, "Oklahoma Endorses Undetectable=Untransmissable Campaign for Persons Living With HIV" https://www.ok.gov/health/Prevention_and_Preparedness/Sexual_Health_&_Harm_Reduction_Service/U=U_Statement/index.html Accessed August 10, 2020
[86] Prevention Access Campaign, "Resources for Providers" https://www.preventionaccess.org/providers
[87] Oklahoma Health Care Authority "SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design" http://okhca.org/mco/ Accessed August 10, 2020
[88] Mahajan, Anish P et al. "Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward." *AIDS (London, England)* vol. 22 Suppl 2,Suppl 2 (2008): S67-79. doi:10.1097/01.aids.0000327438.13291.62
[89] Centers for Disease Control and Prevention, "Dealing with Stigma and Discrimination" https://www.cdc.gov/hiv/basics/livingwithhiv/stigma-discrimination.html Accessed August 10, 2020
[90] HIV.gov "Standing Up to Stigma" https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma Accessed August 10, 2020
[91] "What is HIV stigma?" CDC.gov https://www.cdc.gov/hiv/basics/hiv-stigma/index.html
[92] "What is HIV stigma?" CDC.gov https://www.cdc.gov/hiv/basics/hiv-stigma/index.html
[93] HIV.gov "Standing Up to Stigma" https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma Accessed August 10, 2020

perspectives and needs of LGBT people should be routinely considered in public health efforts to improve the overall health of every person and eliminate health disparities."[94]

ViiV Healthcare supports appropriate education and awareness on HIV which seeks to reduce stigma and discrimination against PLWH and populations at high risk for HIV. We would like to suggest that the state issue a Medicaid Information Bulletin to all providers in the state with resources and information about stigma, HIV, and the populations disproportionately affected by HIV including LGBTQ populations, and also require the MMCOs to provide information to their networks on the same.

4. Medically Frail Populations in Medicaid Expansion

From the questions indicated in the OCHA RFPF[95] it appears that the state will allow the MMCOs to develop Alternative Benefit Plans (ABP) to offer to the Expansion population.

ViiV urges Oklahoma to ensure PLWH are ensured access to necessary medical care and treatment by designating PLWH as a medically frail population in the state Medicaid program in order to allow PLWH to make an informed choice between the ABP that will be offered to the expansion population by the MMCOs or the traditional state plan benefit package.

Medically frailty as defined in federal regulation 42 CFR 440.315 says, *"… the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those … with serious and complex medical conditions…"*[96] According to one analysis, this means that CMS has left it up to the states to establish their own definition.[97] However, CMS also took further steps to ensure medically frail populations would be exempted from Medicaid initiatives that might cause disruptions to enrollment or accessing necessary medical care in their 2018 guidance to state Medicaid programs, which required that medically frail populations be exempted from disenrollment penalties.[98]

Many states have defined populations that should be protected within Medicaid due to their health and medical needs in their definition of "medical frailty" including Kentucky,[99] Virginia,[100] Indiana[101] and Arizona.[102, 103] In a best practice example, in 2018 the State of Michigan submitted a Medicaid demonstration waiver (Healthy Michigan Plan §1115 Demonstration Waiver Extension Application / Project No. 11-W-00245/5)[104] to CMS, implementing a work requirement for the Michigan Medicaid

[94] CDC.gov "Lesbian, Gay, Bisexual, and Transgender Health" https://www.cdc.gov/lgbthealth/index.htm
[95] Oklahoma Health Care Authority "SoonerCare Comprehensive Managed Care Program Request for Public Feedback in Program Design" http://okhca.org/mco/ Accessed August 10, 2020
[96] Government Publishing Office, "42 CFR § 440.315 - Exempt individuals," https://www.govinfo.gov/content/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec440-315.pdf.
[97] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40.
[98] CMS, SMD: 18-002, "RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 11, 2018 https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf Accessed April 6, 2020.
[99] "Kentucky Medically Frail Medical Condition Guide v5," 2018 https://passporthealthplan.com/wp-content/uploads/2018/06/PROV02104-Kentucky-Medically-Frail-Medical-Condition-Guide-Provider-v5.pdf Accessed 4/14/2020
[100] "Medicaid Expansion Overview - Virginia Department of Health," PDF, Sep 19, 2018 http://www.vdh.virginia.gov/content/uploads/sites/10/2018/09/For-Posting_Medicaid-Expansion-Overview_KAS_092618.pdf Accessed 4/14/2020
[101] Indiana.gov, Family and Social Services Division, "Conditions that may qualify you as medically frail," https://www.in.gov/fssa/hip/2465.htm , Accessed March 10, 2020.
[102] Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 2017 https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf.
[103] Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40.
[104] Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

expansion program. The State of Michigan took a commendable step in responding to the concerns of patient advocates to ensure that PLWH were able to maintain access to vital health benefits while the state pursued its new program goals. In the proposal submitted to CMS,[105] the state exempted medically frail individuals from the demonstration, including PLWH through the use self-attestation and/or using claim analysis codes specific to HIV. This process is notable because most PLWH are "automatically" exempted without need for further action on their part.

The medically frail designation is intended to ensure that enrollees with high need for medical care and treatment – such as PLWH - receive the benefit package that best meets their needs if the state does not align the expansion adult Alternative Benefit Plan (ABP) with the state plan benefit package. [106] Enrollees who are designated medically frail are provided the option to either choose the expansion adult ABP or instead access the state plan benefit package if they choose.[107] There are twelve states that have medical frailty determinations in place because their expansion adult ABP is not aligned with their state plan benefit package, including: Arkansas, California, Indiana, Iowa, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, North Dakota, and West Virginia.[108]

If the MMCOs are to offer an ABP to the expansion population, the state is required to identify enrollees who are medically frail as part of that process.[109] We encourage Oklahoma to specifically designate PLWH as a medically frail population. Doing so will help to facilitate the goals of the EHE and ensure PLWH in Oklahoma have access to the coverage option most likely to facilitate their medical needs.

5. Quality Reporting for MMCOs Should Include HIV Measures

In its Oklahoma Integrated HIV Prevention and Care Plan for 2017-2021 report, Oklahoma at the end of 2015, reported a viral suppression rate of 46.8 percent.[110] The CDC states that 60 percent of PLWH in America are virally suppressed, and the national goal is 80 percent.[111]

The "HIV Viral Load Suppression (VLS)"[112] measure is the gold standard in HIV quality, as it signifies that a patient has reached the goal of HIV treatment, which is viral suppression. When a patient becomes virally suppressed, it means that the virus has been reduced to an undetectable level in the body with standard tests.[113] The National Institute of Allergy and Infectious Diseases (NIAID) recently supported research that demonstrated that achieving and maintaining a "durably undetectable" viral load not only

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[105]Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

[106] Kaiser Family Foundation, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," Musumeci, et al : https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/. Accessed on August 10, 2020.

[107] Kaiser Family Foundation, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," Musumeci, et al : https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/. Accessed on August 10, 2020.

[108] Kaiser Family Foundation, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," (Figure 3): https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/. Accessed on August 10, 2020.

[109] Kaiser Family Foundation, "Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults," Musumeci, et al : https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/. Accessed on August 10, 2020.

[110] Oklahoma Integrated HIV Prevention and Care Plan Including Statewide Coordinated Statement of Need 2017-2021 https://www.ok.gov/health2/documents/Oklahoma%20Integrated%20HIV%20Prevention%20and%20Care%20Plan.pdf Accessed. March 31, 2020.

[111] HIV PREVENTION,OKLAHOMA, CDC.gov https://www.cdc.gov/hiv/pdf/policies/profiles/cdc-hiv-oklahoma-PrEP.pdf. Accessed March 31, 2020.

[112]HIV/AIDS Bureau Performance Measures, "HIV Viral Load Suppression," https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/coremeasures.pdf Accessed May 15, 2020

[113] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.

preserves the health of PLWH, but also prevents sexual transmission of the virus to an HIV-negative partner.[114] This builds a strong case for implementing a process and outcome HIV-focused, quality measures to encourage testing, linkage to care, and ongoing treatment so PLWH can achieve viral suppression and ultimately improve their health outcomes.

Evidence-based quality measures assessing HIV care exist, are endorsed by the National Quality Forum (NQF) and are used in federal programs such as the Healthy Adult Opportunity, the Merit-Based Incentive Payment System (MIPS) and the Ryan White HIV/AIDS Program.[115,116] HIV quality measures are critical to elevating the importance of the care and treatment of people living with HIV and for reducing the incidence of new HIV infections. The HIV care continuum and measurement framework of diagnosis, treatment, retained in care, and viral suppression leading to prevention is aligned with the Institute for Healthcare Improvement's Triple Aim of improving patient experience, reducing cost and improving population health.[117] Additionally, the implementation of HIV quality measures across states' quality-reporting programs will help realize EHE goals over the coming decade.[118]

Since Medicaid is the largest source of health care coverage for PLWH, it is imperative for Medicaid programs to prioritize HIV care and viral load suppression by measuring and reporting VLS in order to align with the EHE strategies of rapid treatment and HIV transmission prevention.[119] Several state Medicaid programs have linked HIV quality measures to MMCO performance, thus incentivizing achievement of viral suppression for their PLWH. For example, the New York State's Ending the Epidemic Plan recommends that HIV providers, facilities, and managed care plans report and monitor viral suppression rates and provide financial incentives for performance.[120] Consequently, New York State's Department of Health requires MMCOs to report HIV-specific measures, including the VLS outcome measure, and awards financial incentives based on performance on these HIV measures.[121] New York MMCO's efforts have significantly improved viral suppression rates among Medicaid beneficiaries; by linking many PLWH to care, MMCOs report that more than 40 percent of their Medicaid beneficiaries have achieved viral suppression.[122]

Louisiana's Medicaid managed care program, Bayou Health, has included the VLS outcome measure in its contracts with MMCOs. To further drive improvement, MMCOs have incorporated resources from the Louisiana Office of Public Health's (OPH) STD/HIV Program into disease management programs after the state added measures to their contracts. The MMCOs will continue to support the ambitious HIV care and treatment programs that have achieved 57 percent viral suppression among PLWH in Louisiana.[123]

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[114] NIAID, https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable.
[115] Quality Measures. Quality Payment Program. htps://qpp.cms.gov/mips/quality-measures.
[116] Performance Measure Portfolio. HRSA. https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio. Accessed March 27, 2020.
[117] The IHI Triple Aim. IHI. htp://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.
[118] Department of Health and Human Services. 2019. "Ending the HIV Epidemic: A Plan for America." https://www.hhs.gov/sites/default/files/ending-the-hiv-epidemic-fact-sheet.pdf.
[119] Kaiser Family Foundation. (October 1, 2019). Medicaid and HIV. Retrieved from https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
[120] New York State Department of Health. 2015 Blueprint. Retrieved from https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf.
[121] NASHP. December 2017. Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV. Retrieved from https://nashp.org/wp-content/uploads/2017/09/HIV-Affinity-Provider-MCO-Engagement-Brief.pdf.
[122] New York State Department of Health. Ending the Epidemic Progress Report: March 2018. Retrieved from https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Executive_Summary_2018_.pdf.
[123] Louisiana HIV/AIDS Strategy 2017-2021, published by the Louisiana HIV Planning Group; August, 2016. Accessed at https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf.

ViiV Healthcare applauds the state of Oklahoma for currently collecting and reporting 20 out of the 25 mandatory measures identified in the Adult Medicaid Core Set.[124] We strongly encourage OHCA to also report on the VLS outcome measure, which is included in the Core Set.

However, given the difficulty for some states in collecting and reporting VLS, "Retention in Care" measures for PLWH could serve as a positive surrogate endpoint of high-quality HIV care.[125] PLWH who receive long-term clinical care are more likely to begin antiretroviral therapy and achieve viral suppression, dramatically lowering the risk of transmitting HIV to others.[126,127,128] Conversely, PLWH who are diagnosed, but not retained in care are estimated to transmit the virus to an average of 5.3 people per 100-person years.[129] Because long-term HIV care is strongly associated with viral suppression and optimal health outcomes for PLWH, OHCA could consider measuring retention in care, which includes adherence and medical visits frequency quality measures, as an initial step in HIV quality measure reporting, and moves towards the goals of VLS.

Another HIV measure, the Pharmacy Quality Alliance's (PQA) *Antiretroviral Proportions of Days Covered* adherence measure (PDC-ARV),[130] could facilitate an improvement in adherence to HIV medications, which is especially important in HIV due to the impact to PLWH on their quality of life and life expectancy, but also in terms of lowering HIV transmission risk to others.[131] Additionally, adding the PDC-ARV measure would not substantially increase burden to health plans, as many are already collecting and reporting this data to CMS.

Additionally, we encourage the inclusion of a HIV screening measure as part of the state's opioid efforts. The *Use of Pharmacotherapy for Opioid Use Disorder* measure will support preventive care and treatment while reducing transmissions of HIV. According to the CDC, substance use disorders are closely associated with HIV and other sexually transmitted diseases.[132] In PLWH, substance use can also lower adherence to treatment and worsen health outcomes.[133] Health officials in several states have reported increased HIV transmissions due to injection drug use currently driving the opioid epidemic.[134,135] To address this, the USPSTF and the American Society of Addiction Medicine (ASAM) have both recommended frequent HIV screening for people who inject drugs, as well as screening for HIV while

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[124] "SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application," Oklahoma Health Care Authority, page 54: http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24572&libID=23555. Accessed March 31, 2020.
[125] Roscoe, C. and Hachey, D.M. (2019). Retention in HIV Care . National HIV Curriculum
[126] Crawford TN (2014). Poor retention in care one-year after viral suppression: a significant predictor of viral rebound. *AIDS Care. 26*(11):1393-9. https://www.ncbi.nlm.nih.gov/pubmed/24848440.
[127] Yehia BR, French B, Fleishman JA, Metlay JP, Berry SA, Korthuis PT, Agwu AL, Gebo KA (2014). Retention in care is more strongly associated with viral suppression in HIV-infected patients with lower versus higher CD4 counts. *Journal of Acquired Immune Deficiency Syndromes. 65*(3):333-9. https://www.ncbi.nlm.nih.gov/pubmed/24129370.
[128] Robertson M, Laraque F, Mavronicolas H, Braunstein S, Torian L (2015). Linkage and retention in care and the time to HIV viral suppression and viral rebound – New York City. *AIDS Care. 27*(2):260-7. https://www.ncbi.nlm.nih.gov/pubmed/25244545.
[129] Skarbinski J, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. *JAMA Intern Med*. 2015;175(4):588-596.
[130] PQA, the Pharmacy Quality Alliance, Proportion of Days Covered: Antiretroviral Medications (PDC-ARV) https://www.pqaalliance.org/measures-overview#pdc-arv. Accessed April 14, 2020.
[131] Department of Health and Human Services. HIV Treatment: The Basics. March 2020. Retrieved from https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/51/hiv-treatment--the-basics. Accessed April 13, 2020
[132] Centers for Disease Control and Prevention (2019). HIV and Substance Use in the United States. Retrieved from https://www.cdc.gov/hiv/risk/substanceuse.html.
[133] Centers for Disease Control and Prevention (2019). HIV and Substance Use in the United States. Retrieved from https://www.cdc.gov/hiv/risk/substanceuse.html.
[134] Northern Kentucky Health Department. Press Release: *"Health Officials See Increase in HIV Infection Among Individuals Who Inject Drugs."* January 9, 2018. https://nkyhealth.org/2018/01/09/health-officials-see-increase-in-hiv-infection-among-individuals-who-inject-drugs/.
[135] Massachusetts, Department of Public Health, MDPH Clinical Advisory, HIV Transmission through Injection Drug Use, November 27, 2017. https://hmccreg3.org/wp-content/uploads/sites/90/2017/12/112707ClinicalAdvisory_HIV.pdf.

assessing and diagnosing opioid use disorders.[136,137] The CDC recommends HIV screening as routine care for all adults and adolescents, but advocates for more frequent screening for people who inject drugs.[138]

Optimal outcomes for PLWH can only occur if systems are measured and are able to benchmark their performance against the current standard of care in the HIV care continuum. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.[139]

Conclusion

Thank you for your consideration of our comments. We hope the state will work towards the goal of Ending the HIV Epidemic through assuring that PLWH have open access to life-saving medical treatment and necessary high-quality medical care as the state moves forward with implementing an MMCO system for the Expansion population. Please feel free to contact me at (217) 652-5891 with any questions.

Sincerely,

Heather Eagleton
MidWest Government Relations Director,
ViiV Healthcare

[136] American Society of Addiction Medicine (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Accessed at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24.
[137] USPSTF (2019). Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement. *JAMA 321*(23):2326-2336. https://jamanetwork.com/journals/jama/fullarticle/2735345.
[138] Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, Clark JE (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR. 55*(RR14);1-17. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.
[139] HIV Medicine Association. Tools for Monitoring HIV Care: HIV Clinical Quality Measures (Updated) February 2015. Available at: http://paetc.org/wp-content/uploads/2015/04/Tools_for_Monitoring_Issue_Brief_update-April-2015.pdf. Accessed April, 14, 2020.

SoonerCare Comprehensive Managed Care Program
Request for Public Feedback

Youth Villages is responding to the request for public feedback on the program design of Oklahoma's managed care program. Youth Villages is a national nonprofit with expertise in providing evidence-based intensive in-home, transitional living, and residential services for young people involved in child welfare, mental health, and juvenile justice systems. Youth Villages provides direct services in 14 states and clinical and administrative expertise to partner organizations in 8 additional states. Youth Villages works with the Medicaid systems in the majority of these states, including numerous managed care entities. Despite extensive experience providing services within multiple Medicaid and managed care systems, Youth Villages is not a managed care expert. This response is from the lens of a direct service provider of behavioral and mental health services for young people and families.

In Oklahoma, Youth Villages provides two community-based services that are billed by Medicaid in other states.

- **Intercept** – An intensive in-home service model, powered by GuideTree, serves young people and their family in their own homes and community at times that are convenient for them. Intercept is family-based and systems-focused. It incorporates multiple environmental factors (i.e. family, school, friend groups, etc.) into an individualized treatment plan to address the root causes of referral behaviors and multiple social determinants of health. Intercept specialists meet with the young person and family an average of three times per week and is on-call 24/7 to respond in person if a crisis occurs.
- **LifeSet** – An evidence-based transitional living program model, powered by GuideTree, that serves young adults who are at risk of or aged out of custody. LifeSet is the only transitional living model that shows positive impacts across multiple domains (i.e. housing, employment, education, interpersonal relationships, etc.). This is especially notable because LifeSet is not a housing-based model. LifeSet incorporates youth voice into the development of the young adult's individual treatment plan and focuses on areas of high value to the young person, including relational permanency. LifeSet specialists meet with the young adult in their home or community an average of once per week and is on-call 24/7 to respond in person if a crisis occurs.

A system known as **GuideTree** supports each service. GuideTree includes 3 critical success elements that enhance our programs:

1) A case conceptualization process using a unique causal model linking evidence-based interventions to 24 common referral behaviors,
2) An individualized consultation process that pairs each specialist with a Licensed Program Expert who guides treatment and provides clinical oversight, and
3) An online platform providing real-time access to interventions and other tools and resources allowing the specialist to best prepare for sessions and update a young person's treatment plan.

Youth Villages also provides therapeutic residential services in Memphis, TN to a small number of Oklahoma young people whose needs are too intense for local providers to address.

Managed Care Enrollees:

Q: Should the state require each MCO to enroll all populations or should the state allow specialty plans such that an MCO could propose to serve only certain populations, such as children in foster care, American Indians/Alaska Natives, people with Serious Mental Illness, or other groups?

Youth Villages recommends that the state allow MCOs to create specialty plans, especially for children in foster care. A single specialty plan would operate as a single point of access for all child welfare-involved young people, families, providers, and agencies. A single point of access will help ensure better care coordination and a smoother transition between placements for a highly mobile population with fewer disruptions in care.

Q: How can MCOs better engage individuals in their health care and healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

As a best practice to engaging members, Youth Villages recommends that MCOs provide an intensive in-home service option. Intensive in-home services effectively engage young people and families who are at risk of removal or placement in a higher level of care by providing services directly in the home. Availability and accessibility of clinically appropriate behavioral and mental health services is consistently a major barrier to successfully engaging this population.

From the beginning, Youth Villages has been committed to providing individualized, community-based services in the homes or community of clients at times that are convenient for their schedules. Providing home-based services where the counselor travels to the family or young person increases the likelihood that transportation, work schedules, or child-care barriers will not prevent a family or young person from engaging in services. Customizing treatment plans and evidence-based interventions to the individualized needs of the young person or family also increases service engagement and customer satisfaction. Additionally, Youth Villages initially prioritizes treatment around an area of high-value to the family before addressing other referral behaviors to increase buy-in and participation in services.

Intensive in-home services also naturally lend themselves to addressing social determinants of health by engaging with families and young people directly in their homes and communities, while addressing multiple factors in the family environment (i.e. employment, housing, physical health concerns, etc.).

Benefits Provided Through MCOs:

Q: What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

As mentioned previously, providing home-based services is an effective way to ensure young people and families can access behavioral health services. As a part of the intensive in-home model, clinicians should conduct a comprehensive assessment at the beginning of services, which includes a physical health component. Clinicians can assess for any physical health needs and barriers to care, and develop strategies to resolve those problems. These strategies should focus on long-term sustainability so individuals are still able to access clinically appropriate services even after discharge. In-home clinicians can also help families determine other additional supports or services and assist with needed referrals. These case management-type services should be a key part to home-based services and are essential to the holistic healthy functioning of a young person and family.

In addition, for young adults (18+), an evidence-based transitional living program that focuses on multiple domains can also help facilitate services for a young adult across multiple systems – health care, housing, education, etc. Transitional living programs should not be restricted to just housing-based models, but include community-based models that help the young person learn to navigate multiple systems independently and develop sustainable independent living skills.

Q: How could MCOs best facilitate referrals and track outcomes of referrals to social services such as housing assistance, food security, education and employment assistance? How could OHCA measure MCO performance on social risk factor mitigation strategies?

In our experience, MCOs only utilize claims data to measure performance. Youth Villages encourages the MCOs to develop a system to track and account for additional outcome data in addition to claims data.

Q: How can MCOs improve access to evidence-based behavioral health care, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication-assisted treatment for opioid use disorder, or assertive community treatment?

To improve access to evidence-based behavioral health care, MCOs should be given:

- The incentive and flexibility to find and provide evidence-based services or best practices that fully meet the needs of their members, including services outside of the state plan.
- The flexibility to contract with multiple providers and hold them accountable to meeting the clinical standards of the evidence-based model or best practice vs the standards set by other entities (including the state).
- The ability to fully reimburse providers and negotiate individual rates and rate structures with their providers, since innovative and comprehensive services do not typically lend themselves to 15 minute billing units.

MCOs will find the interventions and services that work best for their members, but the state must support them by giving them the flexibility to provide these needed services and the ability to reimburse providers appropriately.

Q: What types of value-added services would be impactful for members in terms of improving health outcomes, prevention and member satisfaction?

The most impactful value-added services for which we have expertise on would be the inclusion of intensive in-home and evidence-based transitional living services based on science and best practices.

- Eligible intensive in-home service models should be high-intensity (meeting with the young person or family multiple times each week and on-call 24/7), time-limited, home-based, and individualized. Services should also utilize evidence-based or research-informed interventions with performance or outcome measures, as well as be under the clinical supervision of a licensed professional. Eligible models should also be able to demonstrate evidence of effectiveness in working with the target population.
- Eligible evidence-based transitional living service models should be high-intensity (meeting with the young adult at least once per week and on-call 24/7), time-limited, home-based, and individualized. Services should also utilize evidence-based or research-informed interventions with performance or outcome measures, as well as be under the clinical supervision of a licensed professional. Eligible models should also be able to demonstrate evidence of effectiveness in working with the target population.

These two models improve health outcomes by focusing on the social determinants of health that may be negatively impacting the young person or family. Each model addresses referral behaviors and connects young people and families to long-term supports and services for the maintenance of positive, long-term outcomes.

Through home-based delivery of appropriate therapeutic interventions, both models prevent young people and families from requiring a higher-level of care including, but not limited to, an out-of-home placement, hospitalization, or congregate care.

Each model also focuses on member satisfaction by:

- Services being youth and family-driven.
- Meeting with the young person and family directly in their home or community.

- Creating therapeutic goals in collaboration with the young person.
- Focusing on areas of high-value for the young person or family to increase therapeutic engagement.

Quality and Accountability:

Q: What mechanisms should the state use to incentivize MCOs to improve member outcomes?

Youth Villages recommends the state enter into risk-based, capitated contracts with MCOs, while giving MCOs the flexibility and ability to reimburse providers for services they deem appropriate and important for their members with rates that sustain those services. MCOs should also have the flexibility to negotiate rates and rate structures with individual providers to provide the services that best meet their members' needs. MCOs can then be incentivized to enter into value-based purchasing contracts with their own provider network using shared savings agreements, episodic rates, etc.

Care Management and Coordination:

Q: What specific network development, care delivery and care coordination approaches should MCOs be required to employ to better meet enrollees' behavioral health needs?

MCOs should develop a network of providers who provide a range of children's behavioral health and physical health services, including case management, intensive in-home services, foster care, etc. Due to the scientific link between mental and physical health, Youth Villages recommends that care coordination by a requirement for MCOs. However, MCOs should have the flexibility to do so in an way that makes sense to them and their provider network. MCOs should be allowed to determine their own way to coordinate care vs the implementation of a state standard.

Q: What should MCOs do to reduce barriers to care and improve coordination for populations such as children in foster care, AI/AN members, individuals with serious mental illness, justice-involved individuals, and others whose needs present unique considerations?

Youth Villages recommends implementing intensive in-home and transitional living services for all populations due to the flexibility and individualization of service delivery. Intensive in-home and transitional living services reduce barriers and improve care coordination by meeting with individuals in their homes and communities, addressing multiple behaviors and referral issues, as well as helping to navigate additional support and service needs for long-term success.

Provider Payments and Services:

Q: What can OHCA and MCOs do to prepare and help providers to successfully participate in shared accountability models that reward providers for quality and health outcomes?

Youth Villages recommends OHCA and MCOs work with providers on the metrics that they will be responsible to collect and share back to the MCO as a part of the accountability model. These metrics should be meaningful to the MCO and reflective of the long-term well-being of the individual and the impact the program made on their functioning and health. Some work and technical assistance may need to be done to support providers as they adjust to new processes and technology to capture the new metrics.

From: Angie Wright
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Tuesday, August 11, 2020 12:39:12 PM

I have serious concerns about the MCO request that is being planned. I have concerns for both patients as well as professionals. From a patient standpoint I know that profit should not be placed with more importance that health. Managed care often comes down to patients being nothing more that dollars and cents. Patients will have limited access, affecting those who do not have insurance or provider coverage. It limits patients being able to choose their own doctor. And patients will be forced to advocate for themselves and will suffer a loss of privacy. From a professional standpoint, there is a threat of pushing out providers in an already lacking field (especially mental health). Managed care challenges authority, is intrusive in the extent to which clinicians are required to submit documentation for review process, percent of admission requests that are initially denied, and willingness to adapt to review protocols in response to clinicians complaints. Things become standardized.
Please consider these concerns as well as others that I know many professionals are having currently.

Angie Wright, Licensed Professional Counsleor

From: Courtney Boone
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Thursday, August 13, 2020 4:02:50 PM

Good afternoon, let's get real Governor Stitt doesn't want MCOs to improve the health and wellness of Oklahoma people. He wants it so that it will save the state money. How can anyone seriously think that having an organization tell a person what or where they can seek healthcare/mental help from is going to be good for anyone? And let's talk cost, we're going to hire a company and give them millions to cut costs?? That's money that could actually be spent on the people of Oklahoma. This is yet another con by the governor

Courtney Boone, LPC

Assistant Site Director Sapulpa/Assistant Children's Mobile Crisis Director

From: Jeannie
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Monday, August 17, 2020 11:21:56 AM
Attachments: OTA OHCA letter.docx

I concur with the letter sent on behalf of OTA regarding the RFP referenced by #80720200002
Jeannie McMillin
Director
Letter Dixie Transit
Sent from Mail for Windows 10

From: Amanda Hammack
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Wednesday, August 19, 2020 5:55:01 PM

Please do not follow through with the Managed Care Program for Oklahoma. This will severely limit services that are so desperately needed for our state. Funds will then be funneled through another agency that could be used on actual healthcare and not going to people in business suits that have nothing to do with the actual patient care that happens and is needed on a daily basis. I am a registered voter, mental health care worker, and concerned community member living in Tulsa, Oklahoma. I am against Managed Care Programs for our state.

Amanda Hammack, MS, LPC-S
Creeks Health Services
Site Director - Okmulgee
1803 South Wood Drive
Okmulgee, OK 74447

From: Kim Hamilton
To: OHCA Procurement
Subject: [EXTERNAL] 80720200002
Date: Thursday, August 20, 2020 9:18:24 AM

To whom it may concern:
As a person who has worked in community mental health for the past 15 years, and who has also seen a managed care program come and go, it is with urgency that I strongly oppose the idea of implementing another managed care program for the state of Oklahoma Medicaid. In the past the managed care program proved to not work well which is why it was abandoned and a return to current processes was adopted.
I would encourage accurate comparisons be made between the current model and a proposed MCO in the following areas.

- Provider satisfaction surveys/statistics
- Testimonials from providers
- Consumer satisfaction surveys/statistics
- Quality Management statistics
- Previous history in managing state Medicaid benefits.

I appreciate your consideration of these important points.
Regards,
Kim Hamilton LMFT

From: Ashley O
To: OHCA Procurement
Subject: [EXTERNAL] Dental carve out
Date: Thursday, August 13, 2020 3:02:43 PM

Thank you so much for giving us the opportunity to provide input. As a representative of the dental profession in our state I would strongly request that any managed care organization have a dental Carved-out plan and that the terms are presented to a dental focus group prior to being agreed upon by the state. This is essential to the future success of dental access and delivery, as demonstrated in multiple surrounding states. I am available to provide more detail when needed, as this would be essential from all dental healthcare providers perspectives. Thank you again.
Dr. Orynich DMD, MPA, MS
Pediatric specialist

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Dr. Catherine Ashley Orynich
Doctor of Dental Medicine, Harvard School of Dental Medicine
Master in Public Administration, Harvard Kennedy School of Government
Certificate, Pediatric Dentistry, Texas A&M Baylor College of Dentistry
Master in Oral Science, Texas A&M Baylor College of Dentistry
Pediatric Dentist, On the Cusp Pediatric Dentistry

From:	Lynn Means
To:	OHCA Procurement
Subject:	[EXTERNAL] from the Oklahoma Dental Association
Date:	Monday, August 17, 2020 1:38:33 PM
Attachments:	doc02829520200817132934.pdf

Attached (and below), please find our official comments/input regarding the OHCA's search for a qualified managed care organization. Please contact me with any questions. Thank you for the opportunity.

Lynn
F. Lynn Means
Executive Director
Oklahoma Dental Association
www.okda.org

August 17, 2020
Kevin S. Corbett, CEO/Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105
Dear Mr. Corbett,

Thank you again to you and your team for taking time to meet with us earlier this month regarding the Governor's desire to convert the state's Medicaid program to managed care. **The Oklahoma Dental Association (ODA) stands firmly opposed to a capitated managed care Medicaid program.** Capitated payments managed by an out-of-state middleman have a long and entirely unsuccessful history in Oklahoma. Such a program is harmful to our patients and our state's health care infrastructure.

As you know, the ODA works to improve Oklahoma's overall oral health, while advocating for the profession of dentistry, the dentists who work within that profession, and the patients they serve. Therefore, in the spirit of advocacy, should Oklahoma's dental Medicaid program be converted to managed care, we do appreciate the opportunity to submit what we feel are the key elements in a managed care Request for Proposal (RFP), as well as the list of best practices for working with dental managed care organizations. The ODA formed a task force to explore what was/was not working in managed care Medicaid states across

the country, and from their exhaustive work, the following list of critical points in any managed care RFP was developed:

- There should be a dental “carve out” of Medicaid dental funds whereby the state contracts with a Dental Benefits Manager (DBM) to administer the dental program and reimburses dental providers on a “fee for service” fee schedule as opposed to the dental program being capitated and lumped into the medical managed care program.
- There should be at least one designated ODA representative to provide input during negotiating and structuring of a contract between the state and the DBM(s).
- The first step in the provider audit process should be peer review, completed by a dentist(s) or like-specialist.
- The program should be structured as a non-risk bearing program (ASO) or a partial risk bearing program (hybrid) so that fee cuts are not passed on to the dental providers.
- The provider network should be wide open to all dentists and not a closed panel.
- The program should allow dentists currently enrolled in the Medicaid program to participate in the contractor’s network.
- The state should prohibit any requirement for a dentist to enroll exclusively with one contractor.
- The DBM(s) and the state should maintain Medicaid Dental Advisory Committees and the ODA should have representation on such committees.
- Contracts should be designed so that the state doesn’t cede its responsibility for oversight of the health plan(s).
- The state should have a state employee dental director that is an Oklahoma licensed dentist overseeing the health plan(s).
- There should be more than one DBM, creating competition between the DBMs.
- The DBM should provide credentialing and not contract that process to outside organizations.
- The credentialing process should be universal among the DBMs and timely, and provisional credentialing should be allowed.
- Orthodontics, endodontics, etc. should not be limited to specialists, as this severely limits access to care.
- Translation services for providers should be provided free by the state or the DBM(s).
- Nitrous oxide and sedation should be covered at a fair fee.
- A behavior management code should be paid for patients with special needs.
- The number of procedures that must be pre-authorized should be very limited.
- Sealants should be eligible for replacement three years after their initial placement and such service should be reimbursable.
- On molars, a buccal pit filling and an occlusal sealant completed on the same day should be allowable and reimbursable.

In addition to our recommendations from our state task force, please find the attached document listing the best practices when developing a dental managed care RFP, as compiled by the American Dental Association. Keeping in mind the overall health of the citizens of Oklahoma is our primary goal, we can learn from what has worked across the country to ensure a program that removes all barriers to care for those in greatest need.

The ODA appreciates the opportunity to share these recommendations on behalf of our members who are contracted with the OHCA to treat SoonerCare patients and appreciate your earnest consideration. Please feel free to contact our Executive Director, Lynn Means, with any questions.

Sincerely,

Paul Mullasseril, DDS
ODA President
cc: Dr. Mike Herndon, OHCA Chief Medical Officer; Dr. Chris Fagan, ODA President-elect; Dr. Robert Herman, ODA Vice President; Dr. R. Brian Molloy, ODA Dental Care Council Chair; Dr. C. Whitney Yeates, ODA Standing Committee on OHCA Chair and ODA OHCA MAC Representative; and Dr. Karen Luce, OHCA Dental Director

Additional Considerations When Developing an Effective RFP/Dental Contract

Assure Adequate Access

Assuring an adequate network is key to the success of any Medicaid program. Through its contract, the state can assure health equity such that all covered services are as accessible to Medicaid-insured members in terms of timeliness, quantity, duration and scope as the same services are to commercially-covered members in the contractor's region.

- Allow any willing dentist to participate in the contractors' network.
- Allow dentists currently enrolled in the Medicaid program to participate in the contractor's network.
- Prohibit any requirement for a dentist to enroll exclusively with one contractor to provide covered services specifically when there are multiple contractors in a given service area.
- Have written policies and procedures regarding selection and retention of dentists that do not discriminate against dentists who serve high-risk populations.
- Allow enrollees to be able to go out-of-network when specialty services are required if there are no in-network dentists capable/qualified to perform medically necessary services within a reasonable distance/time of where the patient lives. The Medicaid program should reimburse out-of-network dentists in such instances. This is especially important for any child with special needs.

Enrollment and Credentialing

The Medicaid dentist credentialing process is often laborious and time consuming. A state supported common credentialing entity for use across all contractors is ideal. Facilitating a transparent and efficient (online) credentialing process is important for attracting more dentists to a Medicaid program and growing an effective network.

- Adopt standardized criteria and common credentialing entities for credentialing dentists.
- Ensure that all credentialing/re-credentialing applications are processed within thirty (30) calendar days of receipt of a completed application.
- Ensure continuity of care when a dentist is going through the credentialing process (especially for those already participating in the program) when the process takes more than a reasonable time (e.g. 30 calendar days).
- Include an appeals process for dentists not credentialed upon the initial application.

Securing the Dentist-Patient Relationship

Programs should strive to maintain the integrity of the dentist-patient relationship to ultimately achieve high-quality care.

- Ensure enrollees have freedom of choice to change plans and network dentists through a simplified process and without limitations.
- Permit enrollees to obtain covered services from any general or pediatric dentist as the primary care dentist in the contractor's network.

Fee Schedules and Reimbursement

Low reimbursement rates are one of the most significant barriers to dentist participation and beneficiary access. The state should strive to maintain authority in setting the minimum reimbursement rates for covered services.

- Abide by a loss ratio/benefit distribution requirement (annual report). The state should

consider establishing a loss ratio/benefit distribution for contracts to maximize the portion of program expense spent for direct delivery of dental services (i.e., dentist reimbursement). Include clauses in the contract seeking reports of administrative expenses versus expenses spent towards clinical care.
- Provide dentists at least 90 days written notification prior to any change in fee schedule or processing policies.

Claims Processing and Appeals

Slow processing and delayed payment serve as a burden to Medicaid dentists. A best practice is to choose a benefits company with dental claims processing experience to manage the dental benefit. Experience with state and federal regulations governing the Medicaid program would also be beneficial. The state can use the contracting process to uphold timeliness and accuracy of payment.

- Abide by metrics for claims processing. Require the contractor to ensure that 95 percent of claims that can be auto-adjudicated are paid within thirty (30) days of receipt of such claims by the contractor/plan administrator.
- Ensure that the remittance advice or other appropriate written notice specifically identifies all information and documentation that is required when a claim is partially or totally denied. Contractors should include details on all errors in the claim submission rather than sending information on only the first noted error.
- Ensure that all prior authorization requests should be handled within 10-14 days for non-emergency and 48 hours for urgent/emergency situations and there should be clearly written policies explaining when such authorization is required.
- Use the services of an Oklahoma-licensed dentist or like-dental specialist who has appropriate clinical expertise/specialty in treating the enrollee's condition or disease when making decisions regarding prior authorization requests or to authorize a service in an amount, duration, or scope that is less than requested.
- Establish an appeals process to review and resolve dentist appeals. Appeals should be resolved within 30 days.

Role of Peers in Resolving Issues

Appointing a dentist as a dedicated resource to manage the clinical aspects of the care provided to a contractor's Medicaid beneficiaries could help ensure the long-term success of the relationship between the contractor and network dentists.

- Employ a dentist licensed in Oklahoma to manage the clinical aspects of the contract such as proper provision of medically necessary covered services for enrollees, monitoring of program integrity, quality, utilization management, utilization review and credentialing processes.

Monitoring Education and Outreach

The onus of improving utilization of Medicaid dental care to improve and maintain oral health through education and outreach lies with both the contractor and the state.

- Have mechanisms to track missed, late and cancelled appointments in order to conduct targeted outreach to members with repeated occurrences.
- Engage in broad outreach and education activities including promoting oral health as part of systemic health and engage families on the importance of achieving good oral health.
- Engage in targeted outreach such as case management for young children with early childhood caries or case management for those individuals with acute or chronic medical conditions.
- Monitor network use and assist members in finding dentists that accept new patients.

Coordination of Care

Evidence indicates that a greater percentage of children are seen in a pediatrician's office

than by a dentist especially at younger ages. Additionally, evidence increasingly suggests a correlation between medical and dental conditions for adults. It is important for medical and dental contractors to work together to improve referral and establish dental and medical homes (health homes).

- Work with the primary medical contractor on primary care education and initiatives to improve ease of referral between primary physicians and dentists.
- Establish mechanisms to enable medical-dental coordination for Medicaid beneficiaries, particularly for those individuals with co-morbid conditions.
- Assume responsibility for all members seeking care in the emergency department by establishing an emergency department diversion program, helping to ensure the establishment of a dental home.

Contractor Administrative Performance Monitoring

It is important to assure accountability of the contractor to maintain program standards. To that end, the State's use of performance metrics to monitor the administration of the program will help ensure contractor performance. Contractors and subcontractors should have the capacity to generate analytical reports requested by the state enabling the state to make informed decisions regarding contractor activity, costs and quality.

- Report metrics related to program administration on a quarterly basis which includes:
    - Network size
    - Average time to make payment of claims
    - Accuracy of paid claims
    - Response time (call wait time) in dentist call center
    - Response time (call wait time) in enrollee call center
    - Missed calls in each call center
    - Accuracy of dentist directory
    - Grievance and appeals resolution
    - Credentialing times
- Be accredited by a nationally recognized agency. Such accreditation may assure compliance with minimum standards, aiding the state's oversight efforts to ensure proper administration of the dental program.
- Require contractors to monitor and report patient satisfaction with the plan and its network.
- Require contractors to monitor and report dentist satisfaction through annual assessment of the utilization management and quality improvement programs via network surveys. The state should maintain authority for approving the dentist satisfaction survey tool.

Utilization Management

Compliance with administrative record maintenance rules, program coverage rules, medical necessity rules, state policies, requirements of EPSDT and clinical criteria in the dentist manual are generally monitored through claims audits or random chart reviews. Any issues with compliance relating to claim submissions or contract provisions should be identified in a timely manner to avoid retrospective audits that could jeopardize the network. In addition, payers also evaluate treatment patterns across dentists. Dentists are compared with other Medicaid dentists performing similar procedures based on dentist specialty. Dentists whose treatment utilization patterns deviate significantly (specific standard deviation limit) from their peers are then identified as "under" or "over utilizers". Managing compliance and overutilization must be conducted in a manner that is transparent and fair.

- Allow the state Medicaid dental program director to approve all procedures (including edits in the claims system to assure medical necessity) used to monitor compliance and utilization. At minimum, these policies should detail the processes that will be

used to determine “outliers” and applicable benchmarks. It is essential that compliance issues be handled separately from any cases of fraud and abuse and the penalties are structured appropriately.

- Ensure that any audits to determine medical necessity and medical appropriateness of services and treatments are made in consultation with a licensed dentist, who has appropriate clinical expertise/specialty training (same specialty as the treating dentist) in treating the enrollee's condition or disease.
- Have mechanisms to detect underutilization as well as overutilization.
- Provide detailed resources and periodic education and training to dentists and their staffs to inform them about program guidelines and compliance requirements.
- Have readily available mechanisms to resolve disputes by using the ODA’s Mediation Review Program, arbitration or another mutually agreeable process as required by federal law.
- Assure that audits are not structured so as to provide incentives for any party to deny, limit or discontinue medically necessary services to any enrollee.
- Allow dentists to have access to an appeal process. Should a dentist decide to appeal an audit finding, no repayment of potential overpayments are to be made until the appeals process returns a final decision on the findings of the audits.
- Ensure that if fraud is suspected, then the case will be monitored by the State and a clear protocol to handle issues should be in place.

Member and Dentist Manuals

Administrative burden for dentists significantly increases if processing policies are unclear or constantly changing.

- Ensure that plans maintain the most up-to-date member handbook (i.e., beneficiary handbook), which among other details includes the summary of benefits, patient copay information, service limitations or exclusions from coverage, member rights and responsibilities, rules for missed and cancelled appointments and details on when the dentist may need prior authorizations.
- Ensure that plans maintain a dentist manual that serves as a source of information to dentists regarding covered services and frequency limitations, a clear definition for medical necessity, contractors policies and procedures for reimbursement (bundling, downcoding, alternative treatment provisions, etc.), dentist credentialing and recredentialing, grievances and appeals process, claim submission requirements, compliance requirements (including those from state statutes), prior authorization requirements, quality improvement programs and dentist incentive programs.
- Ensure that plans maintain a dentist manual that is thorough and up-to-date, rather than referring dentists to additional websites for coverage and processing policies.
- Easy online access to the dentist manual should be provided to all network dentists.
- Provide the manual to dentists before they are asked to sign the contract.
- Ensure timely dentist notification of any specific policy changes by mail or direct electronic communication (in addition to posting on website).
- Provide detailed resources and periodic education and training to dentists and their staff to inform them about processing policies such as prior authorizations that can be significantly different between MCO’s and increases the administrative burden for a dentist participating in the program.
- Take responsibility for consistency between the member handbook and the dentist handbook in terms of covered services and processing policies.
- Provide copies of the member and dentist handbook to the state for approval and the state should be notified within 30 days when any changes are made.
- Ensure that enrollees have the ability to easily access the network listing that is most

up-to-date. The listing should include information on whether the dentist accepts new patients or not.

- Dentist manuals should have clear language regarding the dentists' rights including but not limited to the following:
    - Obtain information regarding patients' eligibility and claim status in a timely manner.
    - Access to a customer service line with an assurance of minimal wait time to respond to dentist questions.
    - Develop treatment plans needed to bring and maintain patients' oral health.
    - Receive prompt payments on clean claims.
    - Appropriately decline to treat patients who repeatedly miss appointments, are not engaged in maintaining their oral health or are disruptive to other patients in the practice.
    - Not be subjected to retroactive decisions based on credential status (e.g., if a dentist is not re-credentialed, any claims already in the system should not be impacted and the dentist should be provided adequate time to refer patients).
    -

Medical Necessity and Processing Policies

When multiple contractors operate in a state and each administers the dental program differently, the enrollees in the state do not receive the same Medicaid benefit. The state should fully define the list of covered services using the most recent version of the CDT Code rather than simply including "EPSDT services" or "dental services" within RFPs and contracts.

- Abide by the state's definition of covered services. Allow the state to review and approve the benefit coverage and contractual limitations regarding coverage and service frequency determinations.
- Allow the state to review and approve the contractors' claims processing policies and policies relating to prior authorizations and claims for medical necessity. It is important for the state to assure consistency in administration of the dental benefit across multiple contractors within the state.
- Have mechanisms in place to check the consistency of application of review criteria by multiple claims reviewers.

From: Dan Cross
To: OHCA Procurement
Subject: [EXTERNAL] FW: MCO
Date: Thursday, August 13, 2020 4:52:04 PM
Attachments: image001.png
image003.png

Thank you for reaching out to us. Previous attempts at managed Medicaid in this state have not gone well.
If we must move forward, I think the criteria, below, should be considered and should be apples-to-apples comparisons, i.e., data sets match across MCOs. As you are aware, data sets can be configured to prove almost anything. So matching data sets and data collection and processing procedures should be examined.
My suggested criteria include:

1. Previous history managing state Medicaid benefits.
2. Customer/Consumer Satisfaction Survey statistics.
3. Provider Satisfaction Survey statistics.
4. References from providers and interviews.
5. Utilization Review practices (how they manage admissions, cases, levels of care)
6. Utilization statistics (data about the results of their UR process)
7. Quality Management statistics.
8. Network Management policies and procedures (who is contracted, distribution of cases among the network)
9. Interviews by an Oklahoma Provider Committee for all MCO candidates that OHCA & DMHSAS are considering

This is just off the top of my head. If I think of other criteria I will add them later. I wish you the best in this process. A lot is at stake.
Dan Cross, LADC-MH-S
Senior Director, Substance Abuse Services
CREOKS Health Services
PO Box 700360
4103 S Yale Ave
Tulsa, OK 74170-0360
918-382-7300

From: Slatton-Hodges, Carrie <CHodges@odmhsas.org>
Sent: Thursday, August 13, 2020 3:16 PM
To
Subject: FW: MCO
Good Morning,
We want to hear from YOU!
OHCA is extending the deadline for you to submit your input on our search for a qualified managed care organization. You now have until August 21st to send us your comments. Email procurement@okhca.org by 5:00 pm on the 21st. For more information visit www.okhca.org/mco
MELODY ANTHONY

State Medicaid Director
Chief Operating Officer
Oklahoma Health Care Authority
4345 N. Lincoln Blvd. | Oklahoma City, OK 73105
P: (405) 522-7360 | F: (405) 530-7256 | E: melody.anthony@okhca.org

From: outlook_C3AE84ADBE6E5033@outlook.com
To: OHCA Procurement
Subject: [EXTERNAL] Managed Care Program
Date: Friday, August 7, 2020 10:04:15 AM

To Whom It May Concern:
KI BOIS Area Transit System or KATS provides transportation for twelve counties, taking residents to their medical appointments. People are getting served and it is beneficial to the transit systems being able to use these funds to match Federal dollars.
Don't change something that is working for the people and for rural transit systems.
Thank you,
Charla Sloan, Transit Director
KI BOIS Area Transit System
P.O. Box 727
Stigler, OK 74462
Sent from Mail for Windows 10

From:	Jeanette L. Moore
To:	OHCA Procurement
Subject:	[EXTERNAL] Managed Care
Date:	Thursday, August 20, 2020 12:59:34 PM

To Whom It May Concern,
I am **not** in favor of bringing managed care to Oklahoma. If it comes, it is my hope that Aged, Blind, and Disabled will be carved. I do not understand why behavioral health and addiction programs would have to go through a managed care process. Please review the past history. We have done this before and it was disastrous. It delays needed treatment while using up taxpayer dollars. Managed care uses up a lot of my taxpayer dollars when our current system already provides oversight through numerous audits.
Right now Community Mental Health Centers are audited by The Department of Mental Health and Substance Abuse Services for accreditation, by Commission on Accreditation of Rehabilitation Facilities (Carf) which is national accreditation, and each of our programs are monitored and audited by each program we have from ODMHSAS, i.e. drug court, mental health court, Individual Placement Services, Systems of Care, etc. We also have federal audits by Substance Abuse and Mental Health Services Administration (SAMHSA).
This year alone HOPE has provided 2.5 million dollars in pended services that we will not be paid for. This is not just HOPE, it has been common practice with most all of the certified community mental health centers that we have always seen the individuals needing care despite the fact that there is no money left in our state contract. Additional dollars that you would pay a managed care would be better served in compensation for client care. This comes from my heart for being a social worker but it also comes from my head as being a logical business transaction. Allow ODMHSAS to continue to maintain the oversight.
Sincerely,

Jeanette Moore, LCSW

Chief Executive Officer
HOPE Community Services, Inc.
6100 S. Walker
OKC, OK 73139

~~Mission Statement~~: To be a progressive leader in the community providing innovative and supportive mental health and addiction programs that are responsive, efficient, and effective in delivering trauma and recovery focused services that improve the

quality of life for children, families, and adults in our community.

NOTICE OF CONFIDENTIALITY:

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This information has been disclosed to you from records protected by federal confidentiality rules (42 cfr part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the (42 cfr part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. This disclosure may be modified to include state law provisions if those provisions are not contradictory.

From: Jenny Stubblefield
To: OHCA Procurement
Subject: [EXTERNAL] MCO Feedback
Date: Friday, August 21, 2020 11:43:40 AM

Greetings,

I appreciate your efforts in obtaining feedback regarding your search for a qualified MCO. From my experience and research, I highly recommend creating an official Committee/Advisory Board of Providers to directly participate (and continue ongoing review) in choosing a qualified MCO. Not only would this encourage a more thorough and independent selection process, but also provide the citizens of Oklahoma a higher comfort level – based on the prior history of state managed care.

My additional apprehensions are ensuring a MCO does not solely focus on cost saving, but ALWAYS puts the needs of the patient first. Important concerns should be addressed, such as:

*Extended waiting time for patients and/or limited patient care, especially when an advanced level of care requires numerous specialists and/or referrals.

*Higher risk and lack of privacy for patients. Even with privacy laws, additional review and management of patient records creates additional risk of privacy issues.

*Less personal approach for patients. With strict adherence and rigidity in rules, referrals, procedures, and medications – there is higher patient dissatisfaction, people begin to feel like commodities, and it forces individuals (instead of their health professional) to advocate for their health. This, in itself, is taxing and creates unnecessary strain for patients.

Thank you for considering my comments and concerns regarding your search for a qualified MCO. If you need anything further, my contact information is below.

Respectfully,

Jenny Stubblefield

Jenny Stubblefield
Controller
CREOKS Health Services

From: Avery Frix
To: OHCA Procurement
Subject: [EXTERNAL] Reference 80720200002
Date: Monday, August 17, 2020 4:30:08 PM

I support the OTA comments and ask you to adopt the recommendations.

Representative Avery Frix
House District 13

From: Dena Wilson
To: OHCA Procurement
Subject: [EXTERNAL] Reference 80720200002
Date: Monday, August 17, 2020 8:01:23 AM

I agree with the letter sent from Oklahoma Transit Association regarding the transportation portion of this reference. Proper training and background checks, of drivers, as well as required insurance and maintenance of vehicles is key to safety in transporting the precious cargo that is being discussed here, people. Having more than one organization in a region or even in a state that is assigning transportation trips and monitoring required training of drivers and current state of repair and maintenance of vehicles seems to me to be wasted money, duplication of service. The Medical Providers should not be burdened with trying to coordinate transportation, this takes time away from providing necessary care and as we all know there are to few healthcare providers in our state already. Please continue to let the professionals in transit provide the transportation to our citizens in the most cost effective and safe manner possible.
Thank you,

--

Dena Wilson
Executive Director
Muskogee County Transit
PO Box 2973
4401 E. Hayes St.
Muskogee, OK 74402

From:	Greg Reid
To:	OHCA Procurement
Subject:	[EXTERNAL] Response to RFP, Subject # 80720200002
Date:	Monday, August 17, 2020 3:57:09 PM
Attachments:	Oklahoma MCO-081720.docx

August 17, 2020

Oklahoma Health Care Authority
4345 N Lincoln Blvd,
Oklahoma City, OK 73105

SUBJECT: 80720200002

Thank you for the opportunity to comment on the upcoming Medicaid managed care organization RFP.

This response is made by the Oklahoma Ambulance Association (OKAMA), the organized and unified voice for ambulance services in Oklahoma. Formed in 2000, our membership includes urban, rural, and super-rural emergency medical services (EMS) providers operating across our state. Ground Emergency Medical Transportation (GEMT) providers – including county and other governmental EMS providers, private ambulance providers, and hospital-based EMS services – along with air ambulance providers and various affiliates comprise our ranks.

Should you have any questions about these responses or desire additional information, please contact Greg Reid, OKAMA President-Elect, at *redacted* or *redacted*.

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Excluding GEMT and air ambulance providers from the managed care system when conducting 9-1-1 responses and transports would ensure Oklahomans retain access to pre-hospital emergency medical services. Unlike primary care and many hospital-based healthcare providers, GEMT and air ambulance agencies do not know patients' payer sources when dispatched to 9-1-1 calls, as these requests for service are not pre-scheduled. Furthermore, when a patient has suffered serious traumatic injuries, is in cardiac arrest or has unstable vital signs, is unconscious, is under the influence of drugs or otherwise mentally incapacitated, is a minor, or has other special circumstances, frontline providers may not ascertain the patient's payer status until long after transporting the patient to the hospital and transferring his care to a receiving facility. Restrictions related to the response and transport of 9-1-1 patients – including but not limited to approved or preferred hospital emergency room destinations – would be onerous (and in some cases, impossible to satisfy) for frontline providers and dangerous to patient welfare.

Telehealth/use of healthcare navigation lines could help ensure that under-resourced individuals, particularly those with transportation barriers, access the services most appropriate for their immediate medical need without creating onerous restrictions for patients or providers. Too often, individuals call 9-1-1 when they have a non-emergent medical need and either no ability to get to a healthcare facility independently and/or an inability to seek care during customary doctor's office hours.

Oklahoma State Law (§63-1-2504.1) establishes that GEMT has a "duty to act," meaning providers must respond appropriately when called for emergency service regardless of the patient's ability to pay. Due to liability concerns, most Oklahoma GEMT providers follow a strict policy of responding to all requests for services received via the 9-1-1 system. That is, "duty to act" in practice means responding regardless of the patient's ability to pay or medical complaint/condition. This results in overutilization of costly GEMT resources.

The downstream effect is even more troublesome. Oklahoma GEMT and air ambulance providers

are not reimbursed for their response or care provided to a patient on scene (treatment-in-place) unless they also transport the patient to an approved facility (almost always a hospital emergency department). There is no incentive, and a strong liability risk, for providers to refuse to transport a patient to a hospital.

When GEMT providers transport under-resourced patients to a hospital emergency room, the hospital has a "duty to act" under the federal Emergency Medical Treatment and Labor Act (EMTALA). GEMT is not designed to serve primarily as a method of transportation, nor are hospital emergency departments efficient at or designed to provide care for non-emergent healthcare needs.

The lack of reimbursement for treatment-in-place has been recognized on a national level as a problem impacting patients and healthcare providers, and driving downstream costs. The American Ambulance Association is currently working to draft protocols for administration of safe, reasonable treatment-in-place programs.

Respectfully, our three recommendations are as follows:

1. Exclude 9-1-1 GEMT and air ambulance responses and transports from the managed care system.
2. Expand telehealth into Medicaid. This would allow for managed diversion of non-critical patients to more affordable, appropriate treatment options.
3. Reimburse GEMT providers for treatment-in-place. This should save significant money downstream and preserve the capacity of emergency resources for patients who most need them.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?
Utilization of ride-sharing services should be expanded in conjunction with the implementation of telehealth/healthcare navigation lines to ensure more appropriate utilization of GEMT and hospital-based emergency services. Patients with non-emergency needs – such as chronic lower back pain, medication shortages, etc. – could be diverted to clinics or other facilities better suited to the patients' complaints. This would deliver downstream savings and improve care for all Oklahomans by protecting emergency medical transport and treatment capacity.

Greg Reid

From: Brian Ormsby
To: OHCA Procurement
Subject: [EXTERNAL] SoonerCare MCO
Date: Wednesday, August 12, 2020 11:43:20 AM

Working in mental health I am concerned how a managed care program would effect the state of Oklahoma along with those that it is supposed to serve. Managed care is normally implemented to reduce costs and that is also normally done by controlling certain aspects/services that providers are able to give which has a limiting and direct effect on many Oklahomans that desperately need those same services. Oklahoma already has multiple negative marks on our state and the ways that we address these same populations with education, housing, healthcare, etc; we should not add more to that list in order to just save money. I am not sure of what the answer is to solve this problem but implementing a program at the cost of providing services to those that are less fortunate is not the correct answer. If this program is to proceed, there needs to be assurances that it doesn't effect certain programs like CCBHC/Health Home (exclusions) which is already a type of managed care and the program should also allow the person the freedom to choose their own service provider vs. being assigned to one.

Brian Ormsby, M.S., LPC-S, NCC
Director of Operations
Spring Creek Recovery Center
CREOKS Health Services, Inc.
23 E. Ross Ave.
Sapulpa, OK 74066
www.creeks.org/index.php/springcreek

From: Wells, Tina
To: OHCA Procurement
Subject: [EXTERNAL] SoonerCare Request for Feedback - 80720200002
Date: Monday, August 17, 2020 4:37:32 PM
Attachments: image001.png

To Whom It May Concern:

Thank you for the opportunity to comment on the upcoming Medicaid managed care organization RFP.

Global Medical Response (GMR), the largest medical transport company in the world, includes industry leaders in air ambulance and ground emergency medical transportation (GEMT). GMR companies serving in Oklahoma include two GEMT providers and two air ambulance services. American Medical Response (AMR) provides 9-1-1 ambulance service to Duncan and Marlow, Oklahoma; we are also the GEMT (under our Lifeguard EMS brand) in Weatherford, Oklahoma. AMR is also the sole ambulance contractor for the Emergency Medical Services Authority (EMSA). EMSA serves nearly 1.1 million residents in the Oklahoma City and Tulsa metropolitan areas.

Air Evac Lifeteam (Ada, Kingfisher, Claremore, Ponca City, Woodward, Elk City, Altus, Duncan, Ardmore, Idabel, Muskogee, Henryetta, and Duncan) and Med-Trans Corporation (McAlester and Tahlequah) provide air ambulance and critical care transportation services.

GMR is a member of the Oklahoma Ambulance Association and endorses its response (pasted below for convenience). Should you have any questions about GMR's service in Oklahoma or desire additional information, please contact Tina Wells, director of government relations, at *redacted* or *redacted*.

What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

Excluding GEMT and air ambulance providers from the managed care system when conducting 9-1-1 responses and transports would ensure Oklahomans retain access to pre-hospital emergency medical services. Unlike primary care and many hospital-based healthcare providers, GEMT and air ambulance agencies do not know patients' payer sources when dispatched to 9-1-1 calls, as these requests for service are not pre-scheduled. Furthermore, when a patient has suffered serious traumatic injuries, is in cardiac arrest or has unstable vital signs, is unconscious, is under the influence of drugs or otherwise mentally incapacitated, is a minor, or has other special circumstances, frontline providers may not ascertain the patient's payer status until long after transporting the patient to the hospital and transferring his care to a receiving facility. Restrictions related to the response and transport of 9-1-1 patients – including but not limited to approved or preferred hospital emergency room destinations – would be onerous (and in some cases, impossible to satisfy) for frontline providers and dangerous to patient welfare.

Telehealth/use of healthcare navigation lines could help ensure that under-resourced individuals, particularly those with transportation barriers, access the services most appropriate for their immediate medical need without creating onerous restrictions for patients or providers. Too often, individuals call 9-1-1 when they have a non-emergent medical need and either no ability to get to a healthcare facility independently and/or an inability to seek care during customary doctor's office hours.

Oklahoma State Law (§63-1-2504.1) establishes that GEMT has a "duty to act," meaning providers must respond appropriately when called for emergency service regardless of the patient's ability to pay. Due to liability concerns, most Oklahoma GEMT providers follow a strict policy of responding to

all requests for services received via the 9-1-1 system. That is, “duty to act” in practice means responding regardless of the patient’s ability to pay or medical complaint/condition. This results in overutilization of costly GEMT resources.

The downstream effect is even more troublesome. Oklahoma GEMT and air ambulance providers are not reimbursed for their response or care provided to a patient on scene (treatment-in-place) unless they also transport the patient to an approved facility (almost always a hospital emergency department). There is no incentive, and a strong liability risk, for providers to refuse to transport a patient to a hospital.

When GEMT providers transport under-resourced patients to a hospital emergency room, the hospital has a “duty to act” under the federal Emergency Medical Treatment and Labor Act (EMTALA). GEMT is not designed to serve primarily as a method of transportation, nor are hospital emergency departments efficient at or designed to provide care for non-emergent healthcare needs.

The lack of reimbursement for treatment-in-place has been recognized on a national level as a problem impacting patients and healthcare providers, and driving downstream costs. The American Ambulance Association is currently working to draft protocols for administration of safe, reasonable treatment-in-place programs.

Respectfully, our three recommendations are as follows:

1. Exclude 9-1-1 GEMT and air ambulance responses and transports from the managed care system.
2. Expand telehealth into Medicaid. This would allow for managed diversion of non-critical patients to more affordable, appropriate treatment options.
3. Reimburse GEMT providers for treatment-in-place. This should save significant money downstream and preserve the capacity of emergency resources for patients who most need them.

How can MCOs improve access to transportation for SoonerCare members? Should ride-sharing services like Uber and Lyft continue to be options for rides to medical appointments?

Utilization of ride-sharing services should be expanded in conjunction with the implementation of telehealth/healthcare navigation lines to ensure more appropriate utilization of GEMT and hospital-based emergency services. Patients with non-emergency needs – such as chronic lower back pain, medication shortages, etc. – could be diverted to clinics or other facilities better suited to the patients’ complaints. This would deliver downstream savings and improve care for all Oklahomans by protecting emergency medical transport and treatment capacity.

Again, thank you for the opportunity to provide input on this important topic.

TINA WELLS
Director of Government Relations – South Region
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From: Ingrid Gifford
To: OHCA Procurement
Subject: [EXTERNAL] Stakeholder Input
Date: Monday, August 17, 2020 1:03:39 PM

Dear Oklahoma Health Care Authority:

This letter is written in support of Oklahoma Transit Association's position letter regarding transportation and MCOs.

Sincerely,

Ingrid Gifford, CCAP, SPHR
Associate & Transit Director
Southwest Oklahoma Community Action Group, Inc.

From: Micky Flynn
To: OHCA Procurement
Subject: [EXTERNAL] Transit MCO Feedback
Date: Monday, August 17, 2020 4:15:25 PM

To Whom It May Concern,

Please accept this email in full support of the letter with comments from the Oklahoma Transit Association.

Thanks for your full consideration of this support from those who take care of the transportation needs of Oklahomans each and every day.

Best regards,

Micky Flynn

Director of Operations

MAGB Transportation, Inc.

From:	Ted Rieck
To:	OHCA Procurement
Cc:	barnonemark@gmail.com
Subject:	[EXTERNAL] Reference 80720200002 : Comments on Program Design for Planned Comprehensive Medicaid Managed Care Implementation:
Date:	Monday, August 17, 2020 1:52:47 PM
Attachments:	image001.png image002.png image003.png

This is our expression of support for comments made by the Oklahoma Transit Association (OTA) regarding an RFP under development that will seek proposals from qualified managed care organizations (MCOs) regarding the provision of SoonerCare.

Thanks.

Ted J. Rieck, AICP
General Manager
Tulsa Transit
510 South Rockford Avenue
Tulsa, Oklahoma 74120

www.tulsatransit.org