

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

Section I — General Information

The Ohio Department of Medicaid (ODM) is continuing its process of procuring new managed care vendors that will support the future direction of Ohio's Medicaid program. The procurement is a significant step toward ensuring program sustainability, improving quality, and ensuring access to care for the nearly 3 million individuals enrolled in Medicaid. It also gives ODM and the State the opportunity to improve coordination of services for children and individuals in recovery using innovative new approaches that do not fit into the existing Ohio Medicaid managed care structure.

From the outset, ODM's procurement mission has been to focus on individuals, rather than upon the business of managed care. On June 13, 2019, ODM took an unprecedented first step by issuing a targeted Request for Information (RFI #1) not to the managed care business community, but rather directed toward individuals receiving Medicaid services and their families, advocates for individuals, providers, provider associations, partner state agencies, and other persons or organizations with relevant information, opinions, and experiences to recommend improvements to Ohio Medicaid managed care.

The extensive feedback received from individuals, providers, advocacy groups and associations has refined ODM's approach regarding the upcoming procurement and the future of the Medicaid program, and is reflected in this second RFI (RFI #2) directed toward potential vendors, Managed Care Organizations (MCOs) and interested parties. This is NOT the procurement request for applications.

ODM intends to develop a person-centered managed care model focused upon wellness and prevention. Traditional Medicaid MCOs will continue to serve as the foundation of the system, and it is ODM's intent to build upon its past efforts in improving quality of care and advanced payment models. However, there are several new aspects to ODM's reimagined Medicaid program described in this request for information. These aspects include components that are or will be administered separately from the traditional MCO's, and designed and selected as part of related procurement opportunities: (1) the adoption of a single pharmacy benefit manager; (2) the utilization of an administrative services organization responsible for children involved in multiple state systems or with other complex behavioral health needs; (3) the introduction of a fiscal intermediary to serve as a single point of entry for all provider claims and prior authorization requests; and (4) the centralization of all provider credentialing at ODM. Entities other than traditional MCOs are invited to answer any questions relative to these components that may be of interest to them.

Stakeholder Feedback/Themes

As noted above, ODM received tremendous feedback from individuals, providers, and advocacy associations through nearly 1,000 responses to RFI #1. In addition to inviting and receiving responses via email and regular mail, ODM partnered with 42 organizations to hold 19 listening sessions around the State, at which 149 individuals attended.¹ Feedback themes from individuals and advocates include:

- More personalized care is highly desired. Medicaid managed care and the services it provides are often a lifeline for individuals.
- Differences in administration of benefits from one plan to the other causes anxiety and frustration among individuals.
- Transportation challenges are significant and impede individuals' ability to access services (e.g., difficulty accessing timely rides, no shows, late pick-ups, poor customer service).
- Need for enhanced MCO networks to increase access to community-based services, such as dental services, specialty services, behavioral health services, pharmacy services, and services for children.
- Individuals experience confusion around inconsistent and hard-to-understand communications from MCOs (e.g., notices are written in legalese, provider rosters are not up-to-date, websites and benefit handbooks do not clearly list benefits or services provided).

In addition to the listening sessions, ODM held a combined total of approximately 50 meetings around the state with providers, provider associations and other advocates. Feedback themes from providers and provider associations include:

- Confusion caused by the fact that each of the five managed care plans has its own policies and procedures, in addition to ODM fee-for-service policy, effectively resulting in having to navigate six different Ohio Medicaid programs.
- Support for increased standardization and reduced administrative burden in key areas such as billing, credentialing, medical necessity criteria, prior authorization processes and tools, grievances and appeals processes, and denials based on medical necessity to allow providers to spend more time and resources on patient care.
- Support for increased transparency and accurate data sharing between MCOs and providers.

¹ Listening sessions were held in Cleveland, Middlefield, Akron, Lisbon, Steubenville, Marietta, Ironton, Columbus, Cincinnati, Dayton, Waverly, Lima, Toledo, Barberton, and Marysville between October 2, 2019 and January 30, 2020.

- Support expanding and improving access to services for individuals, with a stronger focus on the needs of children served by multiple systems and all those who are recovering from mental illness or substance use disorders.
- Desire for providers to be treated as partners in managed care (e.g., need for better care coordination for adults and children and improved collaboration across care management teams).
- Support for service and payment innovation in managed care, including value-based purchasing arrangements and initiatives to address the social determinants of health.
- Suggestions for improving MCO communications with providers through enhanced MCO staffing (e.g., more provider representatives) and technology (e.g., mobile application, email, text messages, in addition to maintaining a user-friendly website).

Overview of Ohio’s Current Medicaid Managed Care Program

Approximately 90% of persons insured by Ohio Medicaid are enrolled in an MCO.² Specifically, in State Fiscal Year 2019 (July 1, 2018 through June 30, 2019), Ohio Medicaid’s monthly enrollment in managed care was approximately 2.46 million individuals, out of a total 2.73 million full benefit individuals. (The entire Medicaid monthly enrollment for State Fiscal Year 2019 was 2.87 million). ODM’s monthly managed care enrollment reports can be accessed at <https://medicaid.ohio.gov/RESOURCES/Reports-and-Research/Medicaid-Managed-Care-Plan-Enrollment-Reports>. The monthly enrollment report breaks down enrollment by eligibility category (Aged, Blind and Disabled; Covered Families and Children, Expansion, etc.) by current Medicaid managed care plan and region.

ODM contracts with five MCOs, Caresource, Buckeye, Molina, Paramount, and UnitedHealthCare, which were selected through a competitive procurement process in 2012. The MCOs are responsible for covering all state plan medical benefits including behavioral health services and prescription drugs for individuals who are enrolled in the MCO. MCOs must also offer additional benefits, such as member services and care management. The five MCOs each sign a provider agreement with ODM. The provider agreements are uniform in language and requirements. The current provider agreement and past agreements from July 1, 2014 onward can be accessed at <https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans>.

Other state agencies, including the Ohio Department of Aging, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the Ohio Department of Job and Family Services, and the Ohio Department of Developmental Disabilities, assist ODM with the administration of various programs. Individuals in the Medicaid program enrolled with an MCO,

² Approximately 120,000 individuals are enrolled in MyCare Ohio, which is a managed care demonstration program designed for Ohioans age 18 and older who are eligible for both Medicaid and Medicare and reside in one of 29 Ohio counties. These clients are enrolled in MyCare Ohio Plans, which coordinate their physical, behavioral, and long-term care services. This RFI is focused on the Medicaid managed care program, not MyCare Ohio.

may also receive services delivered in coordination with one or more of these agencies or their local counterparts.

The 2012 procurement was regionally based, and the same five plans were awarded each region. Accordingly, each of the five plans provides services on a statewide basis as of the date this RFI is released.³ The current regions and the counties they cover are as follows:

Region	Counties
Central/Southeast	Athens, Belmont, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Morrow, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton, Washington
Northeast	Ashland, Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Holmes, Geauga, Huron, Lake, Lorain, Portage, Medina, Mahoning, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne
West	Adams, Allen, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Defiance, Fulton, Greene, Hamilton, Hancock, Hardin, Henry, Highland, Lucas, Mercer, Miami, Montgomery, Ottawa, Paulding, Preble, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood, Wyandot, Warren

Actual state fiscal year 2019 expenditures for Ohio’s managed care program were \$16.62 billion, within a total projected expenditure of \$17.91 billion for that period. Projected state fiscal year 2020 expenditures are \$19.73 billion. The Ohio Medicaid Budget Variance Report provides a monthly review of actual Medicaid expenditures compared to the budget enacted by the Ohio General Assembly. Current and historical reports from September 2017 to the present are available at <https://medicaid.ohio.gov/RESOURCES/Reports-and-Research/Budget-Variance-Reports>.

Ohio’s Future Managed Care Program

Ohio’s future managed care program will be structured and designed to achieve the following goals:

- Emphasizing a Personalized Care Experience.
- Improving Wellness and Health Outcomes.

³ Individuals residing in the Central/Southeast region will no longer have Paramount as an option for their managed care organization as of June 1, 2020.

- Improving Care for Children and Adults with Complex Needs.
- Supporting Providers in Better Patient Care.
- Creating Greater Confidence in the System through Transparency and Accountability.

ODM releases this RFI #2 to solicit feedback and ideas from managed care organizations and other interested parties to inform the development of the Medicaid managed care procurement, which ODM plans to conduct during calendar year 2020. The purposes of this RFI #2 are to: (1) gauge the capacity of a redesigned managed care system to support changes and innovations ODM is considering for the future of the Ohio Medicaid program; and (2) solicit feedback from respondents regarding best practices and experience in implemented potential new approaches.

Section II — Timeline Information

Anticipated Timetable

Date	Event/Activity
2/4/2020	<p>ODM releases RFI #2 to the Supplier Community on the Ohio eProcurement website.</p> <ul style="list-style-type: none"> • Question and Answer (Q&A) period for inquiries regarding RFI clarification opens. • RFI #2 becomes active. • Interested Parties may submit inquiries.
2/11/2020	<p>Q&A Period Closes (8:00 a.m. EST).</p> <ul style="list-style-type: none"> • No further inquiries will be accepted after 8:00 a.m. EST. • ODM will provide answers to the inquiries on the Ohio eProcurement website as timely as possible. ODM will use its best efforts to post all Answers to the Ohio eProcurement website by close of business on February 18, 2020.
3/3/2020	<p>Deadline for Interested Parties to submit Responses to this RFI #2 to ODM (4:00 p.m. EST).</p>
3/16/2020- 3/27/2020	<p>ODM may interview Interested Parties and/or request written clarifications.</p>
4/3/2020	<p>Request for Clarifications closes (8:00 a.m. EDT)</p> <ul style="list-style-type: none"> • Interested Parties may no longer submit Responses to ODM’s Requests for Clarifications (if any) after this time.

Section III — Internet Question and Answer Period; RFI Clarification Opportunity

Interested Parties are invited to submit clarifying questions regarding this RFI #2 by following the process below:

1. Access the ODM Requests for Proposals Web Page at <https://medicaid.ohio.gov/RESOURCES/Legal-and-Contracts/RFPs>.
2. Select the appropriate posting.
3. Select the “Submit Inquiry” option button.
4. Follow instructions to submit a question, or to view posted questions and answers, select “View Q and A” near the bottom of the webpage.

In submitting a question, the Interested Party must include the name of a representative of the Interested Party, the organization’s name, email address, and business phone number. ODM will not respond to any questions submitted after 8:00 a.m. EST February 11, 2020.

Questions will be answered only if they are submitted using this process and are received before the close of the Q&A period. The answers provided by ODM may be accessed by following the instructions above.

Clarifying questions and ODM responses will be posted on the eProcurement website dedicated to this RFI compiled in the “ODM Q&A.” Answers will only be provided in this forum. Answers obtained outside this process will be null and void.

In the event of any technical difficulties with this Question and Answer process, Interested Parties may seek assistance by contacting the ODM Office of Contracts and Procurement at (614) 502-7117.

Section IV — Format of Response

ODM has structured this RFI into 24 questions across several content areas. Many of the questions have multiple subparts. ODM seeks a similarly structured format for Responses. Responses should indicate the question by number (and subpart, if applicable) and provide a narrative in response. All Responses must be provided to ODM in PDF format.

Respondents are NOT to include ANY trade secret information because the contents of Responses to this RFI will be considered public information and will be made available upon request. Responses to this RFI are to contain general feedback and information; ODM does not seek any information that might be considered proprietary in nature.

ODM may conduct interviews with Respondents to the RFI to gather additional information or obtain clarification. A Respondent MUST respond to the RFI by the deadline for RFI responses in order to be granted an interview. Selection for interviews will be at ODM’s sole discretion. Attendance at an interview will neither increase nor decrease any Respondent’s chance of

being awarded a contract from a subsequent solicitation by ODM. ODM may issue a request for written clarifications before or in lieu of interviews. All responses to clarifications must be received by the close of the Request for Clarifications period.

This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Respondents should note that no contract will be awarded pursuant to this RFI and that responding to, or not responding to, this RFI will neither increase nor decrease any Respondent's chance of being awarded a contract from a subsequent solicitation by ODM.

The State of Ohio is not liable for any costs incurred by a Supplier in responding to this RFI. Respondents may be referred to as "Interested Parties," "Vendors," "Suppliers," or "Respondents".

Section V — Content of Response

Suppliers and other interested parties responding to this RFI should address the following topics and questions associated with Ohio's Medicaid managed care program. Please note, while Respondents are encouraged to submit narrative responses to any or all questions, it is not mandatory to respond to every question.

In addressing the topics that follow, include in your response a description of any person-centered care aspects that are relevant to the information requested.

The topics are:

- Emphasizing a Personalized Care Experience
- Managed Care Structure
- Improving Wellness and Health Outcomes
- Improving Care for Children and Adults with Complex Needs
- Supporting Providers in Better Patient Care
- Creating Greater Confidence in the System through Transparency and Accountability
- General Feedback
- Request for Interview

Emphasizing a Personalized Care Experience

1. **Person-Centered Care** – Through the procurement, ODM intends to improve the engagement and experience of individuals and their families as they access care throughout the Medicaid system.
 - a. How can ODM support MCOs and providers to become person-centered organizations dedicated to improving the experience of individuals they serve?
 - b. Describe strategies MCOs can use to engage members into wellness activities known to improve health outcomes.

- c. Describe how MCOs and providers can leverage technology to communicate with individuals about wellness activities, benefits and health care taking into consideration Ohio's geographical structure including rural vs. urban-specific needs and potential communications barriers (e.g., lack of phone and internet access).
- d. Describe how MCOs and providers can support efforts to reduce the impact of health care disparities, such as geography, race or ethnicity, or income levels.
- e. Describe how MCOs could support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy. How would this be monitored?

Managed Care Structure

2. **Managed Care Organizations and Service Area** — ODM intends to procure MCOs as a foundational component of its Medicaid managed care program. MCOs will be responsible for administering and managing Medicaid benefits under a full risk contract, including behavioral health services, for all populations, other than pharmacy and except for the behavioral health benefit for children served by multiple state systems or with other complex behavioral health needs (see questions 3 and 13 below).
 - a. ODM is considering allowing MCOs to bid on specific regions. Please provide your interest in a regional award or awards versus a statewide award and explain your reasoning.
 - b. Should changes be made to the currently defined MCO geographical regions? If so, what should ODM consider when redefining the regions?
3. **Pharmacy Benefits Management** — As directed by the Ohio General Assembly, ODM will engage with a single pharmacy benefit manager for the managed care program. The pharmacy benefit manager and ODM will be primarily responsible for managing and administering the pharmacy benefit for MCO members. This may include, but not be limited to, maintaining the unified preferred drug list, conducting utilization management, administering pharmacy clinical programs, creating and maintaining the pharmacy network, processing pharmacy claims, reimbursing pharmacy providers, integrating medical and pharmacy claims, conducting data analytics, and exchanging data. The MCOs will receive data exchanges/extracts for their Medicaid members from the pharmacy benefit manager.

The MCO responsibilities may include having an agreement with the pharmacy benefit manager, primarily for data exchange; coordinating and cooperating with the pharmacy benefit manager and ODM to optimize the provision and utilization of pharmacy benefits; providing member information and education and integrating pharmacy data to support member and provider experience; integrating pharmacy data into the MCO's

care management and clinical programs; coordinating with the pharmacy benefit manager and ODM to enhance prescriber and pharmacy provider engagement and pharmacy clinical programs such as medication therapy management; having the option to establish value-based payments for pharmacies; managing the medical benefit; and exchanging data with the pharmacy benefit manager and ODM.

- a. What suggestions do you have regarding the coordination of MCO and pharmacy benefit manager clinical programs?
 - b. How could ODM better align the pharmacy and medical benefits, including physician administered drugs, to improve outcomes for individuals?
 - c. Describe best practices for MCO exchange and integration of pharmacy data with a pharmacy benefit manager.
 - d. Please describe the impact of the above model for Medicaid managed care on the provision of Medicaid and Medicare pharmacy services to MyCare members. Would you suggest that ODM use the same model for the Medicaid pharmacy benefit for MyCare members? Please explain your rationale.
4. **Fiscal Intermediary** — Accurate, timely and actionable data are fundamental to the effective operation of a Medicaid program. Currently, ODM has to conduct special analyses and make additional efforts to collect data from several managed care plans. At the same time, providers report that the inconsistency in business processes across managed care organizations requires additional resources and time that could be better spent on patient care.

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

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

- a. Please identify any potential barriers to implementing this model from the MCO and/or provider perspective and proposed solutions.
 - b. One key goal of this model is to provide a consistent experience for providers across MCOs and fee-for-service. Please describe the advantages and disadvantages of requiring the MCOs to comply with/apply fee-for-service claims processing edits and rules. Please identify the types of edits/rules that should be determined by the MCO, including the rationale.
5. **Enrollment** — ODM intends to redistribute individuals who do not affirmatively select an MCO across all MCOs using an automatic assignment algorithm.
- a. Some states place an enrollment cap or maximum size for any individual MCO. Please share your thoughts on managing or limiting the enrollment size of MCOs.
 - b. What steps should ODM take to manage care transitions to ensure the continuity of care for individuals who may be assigned to a new MCO as a result of redistributing members?

Improving Wellness and Health Outcomes

6. **Health and Wellness** — To improve health outcomes and support individual wellness, ODM will use a state-driven population health strategy designed to reduce infant mortality and preterm births, increase healthy behaviors, promote tobacco cessation, and address healthcare inequities. ODM envisions a robust community-based organization and MCO partnership infrastructure to accomplish this goal.
- a. Describe ways in which MCOs serving the same region can collaborate to create and implement strategies that have a collective impact on the population within the region with specific attention to the issues identified above (i.e., reducing infant mortality and preterm births, increasing healthy behaviors, promoting tobacco cessation, and addressing healthcare inequities).
 - b. Describe how an MCO can progressively work to identify social needs and implement innovative strategies to address social determinants of health in a region including food security, housing, education, and interpersonal violence.
7. **Performance Incentives/Reimbursement Strategies** — ODM is interested in aligning incentives and reimbursement strategies to create a health care system that improves wellness and health outcomes, while better managing financial resources.
- a. Are there specific strategies that ODM should consider to support movement along the continuum of value based care/payment models and align incentives with MCOs and provider partners to achieve greater levels of integration and improved health care outcomes? What should the MCO's role be in supporting

providers in value-based payment models? Are there specific alternative payment models that ODM should consider or promote?

- b. MCO developed, value-based payment arrangements with providers that are not aligned with other MCOs may create additional administrative requirements for providers and dilute the underlying objectives. What level of discretion should ODM give to the MCOs to design their own value-based payment arrangements as opposed to requiring a more coordinated, statewide approach?
- c. ODM is considering linking incentives to outcome metrics for MCOs, providers, or both. Describe recommended processes or capabilities to collect reliable outcome measures from network providers. Please provide examples of outcome measures and how MCOs currently use that information.

8. Quality Improvement –

- a. For entities that have experience in population health approaches, describe the tools and processes that were used to achieve population-level improvements. Describe dedicated staff composition and/or training required to manage these efforts, highlighting areas of success and partners crucial to that success. How might the improvements and lessons learned be integrated into MCO operations?
- b. How can MCOs support better population health management and constant quality improvement at the health-system level? How might those efforts be aligned with the State to maximize collective impact?

9. Employment, Education and Training – Poverty, food insecurity, housing, and employment status can impact an individual’s overall health. Under an 1115 waiver application approved by the federal Centers for Medicare and Medicaid Services, individuals enrolled through Ohio’s Medicaid expansion (Group VIII) will be required to demonstrate they work 20 hours per week or are engaged in other allowable activities, including job search, education and training, or community service.

- a. Describe ways in which an MCO can support work-ready individuals to seek and retain employment.
- b. Describe successful approaches and/or programs designed to educate or train individuals for future potential employment opportunities (e.g., through MCO-sponsored programs, connections with vocational education or other higher education institutions).

10. Dental Services — Stakeholders throughout the State identified the importance of dental services to ensuring improved health outcomes. Describe successful approaches,

from Ohio and other states, for increasing access to dental services, including access to specialty dental services, particularly where there are network gaps, such as rural areas.

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

Improving Care for Children and Adults with Complex Needs

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

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

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

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

ODM seeks input on the following:

- a. In the MCO and CCE model explained above, describe the roles, responsibilities and collaboration among involved entities that will be needed to ensure care access and continuity of care for individuals transitioning between tiers, transitioning between settings and transitioning between MCOs and/or CCEs when necessary. How should roles and responsibilities be delineated to leverage strengths of MCOs and community-based CCEs? How can duplication of effort be minimized across the entities?
- b. Which types of community-based CCEs should be considered for ODM designation? How might MCO systemic support to CCEs vary by the type of entity designated as a CCE? (E.g. what MCO systemic supports are needed for waiver service coordinators, for specialized recovery services⁴ care management agencies, for comprehensive primary care practices?)
- c. In working with a community-based CCE and its care coordinators, what could the MCO do to support individual care needs and remove barriers to support the timely delivery of services? What is the best way for ODM to measure MCO support and responsiveness?
- d. How could MCOs and CCEs meaningfully exchange data and information to improve care outcomes? What types of data and information should be exchanged?
- e. What suggestions do you have for care coordination staffing and qualifications, taking into account both quality and administrative expense? How could alternative staffing arrangements (i.e. team-based care requirements, hub-and-spoke models, etc.) be used to efficiently meet individuals' care management needs?
- f. What recommendations and best practices might help ODM monitor the ongoing quality of care coordination/care management? What approaches could be used to effectively and efficiently monitor performance of both individual care management/care coordination outcomes, and outcomes for the care coordination/care management program as a whole?
- g. What types of structures and processes should be put in place to ensure Care Guides can quickly and effectively meet each individual's time-limited needs? How could ODM monitor the quality and effectiveness of the Care Guide program?

⁴ Ohio's specialized recovery services program is jointly administered by ODM and the Ohio Department of Mental Health and Addiction Services to provide home- and community-based services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions in accordance with Chapter 5160-43 of the Ohio Administrative Code.

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

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

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

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

Critical to the success of this transformation is an effective care coordination approach. ODM and its state partners are interested in developing an Intensive Care Coordination

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

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

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

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

responsibilities and collaboration between involved entities to ensure care access and continuity for individuals.

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

14. Behavioral Health Services — The State continues to work with behavioral health providers, managed care organizations and other stakeholders to stabilize the integration of behavioral health services into managed care.

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

15. Opioid Use Disorder and Substance Use Disorder — Medicaid plays a central role in efforts to address the State's opioid epidemic ranging from the coverage of evidence-based interventions and treatment, providing tools and support to providers, enhancing the State's capacity.

- a. Describe utilization management approaches that ensure individuals have access to substance use disorder services at the appropriate level of care and interventions are appropriate for the diagnosis and level of care.
- b. What efforts are necessary to develop sufficient provider capacity for each level of care, and medication-assisted treatment services in particular, for individuals with substance use disorder and opioid use disorder?
- c. What are ways that the MCOs can support, shape and improve provider performance to expand access and improve outcomes for individuals with substance use disorder and opioid use disorder?

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

Supporting Providers in Better Patient Care

17. **Centralized credentialing** — ODM intends to centralize provider credentialing and re-credentialing. MCOs will accept provider credentialing information from ODM and will not request any additional credentialing information from a provider. MCOs will potentially participate in the ODM -led credentialing committee. MCO responsibilities will include providing credentialing files prior to the start of operation, negotiating and executing provider contracts, notifying ODM of denied provider applications, loading providers into their claim system, and reporting provider information (e.g., member complaints, quality of care issues, changes in provider information, and any provider terminations) to ODM. MCOs will terminate their contracts with providers whose credentials are terminated by ODM.

- a. Please identify any potential barriers to implementing this approach and proposed solutions.
- b. For MCOs, does your organization have delegated credentialing contracts with health care providers? If so, please provide an estimate of the number/percentage and types of providers in your organization's Medicaid network who have delegated credentialing status.

18. **Standardizing Provider Requirements** — Stakeholders have strongly advocated to reduce the administrative burden on providers, which detracts from provider focus on delivering quality care, by standardizing administrative requirements for providers. To address underlying concerns, ODM is considering adding the requirements below:

- MCO use of only state developed standardized prior authorization and concurrent review forms and processes, without additional MCO-specific forms or required information.
- Standardized provider dispute resolution process across all MCOs.
- MCO use of American Society of Addiction Medicine criteria for review of substance use disorder service requests.
- MCO use of state developed medical necessity guidelines, where they exist, to conduct prior authorization and concurrent review.
- Prior review and acceptance of MCO policies as they relate to implementing state developed medical necessity guidelines.
- Prohibition of MCO application of prior authorization for certain services as determined by ODM.

- a. Identify unintended consequences ODM should be aware of when considering these requirements.
 - b. ODM also plans to establish appointment availability standards. Describe best practices for monitoring appointment availability that minimize provider burden.
 - c. Describe strategies for MCOs, individually and collectively, to regularly consider and reduce provider burden and support greater consistency across MCOs.
19. **Workforce Development** — ODM is interested in requiring MCOs to actively participate with each other, ODM and other stakeholders to develop a collective impact approach to workforce development. This could include participating in a stakeholder workgroup to identify target areas and potential strategies, conducting workforce analyses, developing a workforce development plan, and implementing strategies to address target areas. Please provide your ideas for how an MCO could work with ODM and other stakeholders (including other MCOs in the same region/state) in workforce development.

Creating Greater Confidence in the System through Transparency and Accountability

20. Program Integrity —

- a. Pre-payment review activities by an MCO may lead to fewer referrals for fraud, waste and abuse. Please describe the types of pre-payment review activities an MCO might conduct and how an MCO could quantify, and demonstrate to ODM, the amount of cost avoidance due to these activities.
- b. What metrics would you suggest for ODM to measure the efficacy of an MCO's fraud, waste and abuse activities, including number of referrals?
- c. How should an MCO adjust its program integrity approach for value-based payment models such as incentive payments, shared savings, episode-based payments, and sub-capitation? Please describe examples of how this may be operationalized.

21. Data and Information —

- a. Describe best practices for exchange of care management information (e.g., assessment, plan of care, notes, referrals, alerts) between the MCO and contracted and non-contracted care management entities (e.g., ODM, partner state agencies, local administrative agencies, state vendors).
- b. Describe best practices for MCOs to provide ODM with real-time access to their data systems (e.g., virtual access or having ODM staff onsite).

- c. Describe how MCOs could use Ohio health information exchanges and/or other real time data to deliver services and improve health outcomes. What data elements can the MCO share and what is the format of the data? Describe the extent of current utilization of a health information exchange by the MCO and network of providers. Describe ideas of how to work with other MCOs to standardize the approach to data-sharing.
- d. Describe best practices for MCO integration of the MCO's internal systems and incorporation of data from contracted vendors.
- e. Describe considerations that would impact an MCO's ability or plans to apply real-time eligibility updates.
- f. Describe how MCOs might use data and systems to improve the accuracy and timeliness of individuals' eligibility and demographic information, including when an individual's eligibility is pending redetermination.
- g. Describe existing data, other than claims data, that could be used to inform population strategy.

General Feedback

- 22. **General feedback** — What other information should ODM consider as we take the next steps to achieve the goals for Ohio's Medicaid managed care program?
- 23. **Economic Considerations** – The strength of the economy has a countercyclical impact on a state's Medicaid program. Please describe the strategies an MCO might employ to address the negative budgetary effects of an economic downturn, while maintaining a person-centered and effective delivery of care model.

Interview

- 24. **Opportunity for Interview** – Indicate in your Response if your entity/organization would like the opportunity for an interview with ODM to discuss the answers you have provided in Response to the RFI. Attendance at an interview will neither increase nor decrease any Respondent's chance of being awarded a contract from a subsequent solicitation by ODM. If your entity desires the opportunity for an interview, indicate so in your Response and include the following information:
 - a. Name of entity or organization.
 - b. Entity Type.
 - c. Point of contact, including name, telephone number, and email address, for the purpose of scheduling the interview.

- d. Name, title and employer of proposed attendees to the interview, including any contracted lobbyists or consultants.
- e. Brief description of the topic or topics in the entity or organization's RFI response that the entity or organization would propose to address in the interview.

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

Section VI — Trade Secrets Prohibition; Public Information Disclaimer

Interested Parties are prohibited from including any trade secret information, as defined in the Ohio Revised Code (ORC) § 1333.61, in their submissions in response to any RFI. ODM shall consider all Responses voluntarily submitted to be free of trade secrets, and such Responses if opened by ODM will, in their entirety, be made a part of the public record, and shall become the property of ODM, pursuant to ORC § 149.43.

Section VII — Response Submission Procedures

ODM requests Responses to be submitted in electronic format and emailed to the ODM Office of Contracts and Procurement (OCP) for receipt no later than **4:00 p.m. EST on March 3, 2020** at the following email address: ODM_Procurement@medicaid.ohio.gov. No other method of submission will be accepted. Respondents will receive a confirmation e-mail from OCP within one business day of receipt of response.

Please convert the Response into one single PDF document attached to the email. If the submission's size necessitates more than the two PDF documents to contain the entire Response, please use the fewest separate PDF documents possible.

All submissions must be received by OCP by the specified deadline. Materials received after the deadline will not be added to any previously received submissions. Submissions must contain the organization's name, the RFI title and number, and the submission date. The electronic copy may be used by ODM for archiving and public records requests. OCP will accept submissions at any time prior to the posted submission deadline (March 3, 2020 at 4:00 p.m. EST). ODM is not responsible for submissions incorrectly addressed or sent to any email other than the address specified above.

Thank you for your efforts to provide ODM with your suggestions, comments and relevant information to assist with the reimaging of Ohio Medicaid's managed care program.