OHIO ASSOCIATION OF
MEDICAL EQUIPMENT SERVICES

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Ohio Department of Medicaid
Office of Contracts and Procurement
Managed Care Procurement RFI
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OAMES Overview:

OAMES has distributed the RFI to members encouraging their participation and urging them to share it with Medicaid recipients as well as the clinical and administrative teams who are part of the continuum of care process for providing home medical equipment (HME) services. Given OAMES is not a provider, our comments focus on feedback we've heard from members or have been developed within our workgroups, many of which are being discussed in on-going efforts today with ODM and managed care plans. You'll find we responded to select questions as numbered related to the role of the HME provider community.

Communication and Engagement with Individuals Enrolled in Managed Care Plans

Provider search

7. How could managed care plans make it easier for individuals to search for providers? In particular:
   - What tools and resources would be most helpful (e.g., calling member services, online provider directory, hard copy provider directory, mobile application)?

   OAMES: *OAMES members report that online directories of MCPs' providers are not kept current. HME providers may be listed that are out of business, have moved, or may no longer be providing certain services. This is very important to ensure appropriate capacity in the broad HME benefit. HME companies may be specialists in one service area (i.e. respiratory) or focus on a select patient population (i.e.*

pediatrics) or they may be full service and provide a wide range of services. It's important to understand the specific focus of each contracted provider to ensure HME recipients have adequate access to the full ranges of products/services that are prescribed for their unique medical needs.

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

***OAMES**: As noted above, there are a wide range of services and products that fall under the HME benefit including standard items such as mobility aides, hospital beds, and medical supplies to life-sustaining and complex services such as respiratory, individualized seating systems, power wheelchairs and more. It's important that the network of HME companies be individually assessed to ensure that individuals have access to all products and services for their medical needs*.

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

***OAMES:** Perhaps live links to each HME provider through the plans' online provider directory would allow consumers to find the provider that best suits their needs. This should also catch any provider that may have closed/exited the area which could in turn help keep the directory updated and accurate. Also, it would be ideal to sort by provider type.*

Grievances and Appeals

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

***OAMES:** Routinely assess the beneficiaries' satisfaction especially during any transition to a new HME provider. Individuals should be asked if the transition from provider to provider was efficient and convenient, to rate if services are easier or harder to obtain (including things like speaking to a HME representative, telephone hold wait times, etc.), if the new provider's quality of products and service is better, worse or the same as the previous provider and if access to medically necessary services are better, worse or the same. Also assess the prescribers (physician) satisfaction with the transition to a new provider. Focus should be on whether the program increases or decreases the burden on the prescriber in order to obtain as much efficiency in care delivery as possible for all in the Medicaid program.*

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

***OAMES:** Establish a trackable, electronic claims mechanism for appeals, MCP requests for additional medical necessity documentation, corrected claims or claim resubmission mechanism via the MCP's Internet Portal or via an established electronic claims software (eliminate use of fax, mail or paper requests from MCPs to providers).*

Also, the peer to peer review process used by some MCPs is too inconsistent. This also leads to unacceptable denial reasons. For example, we've heard from members that Aetna uses this process and HME providers' customers have received denials stating "it is the responsibility of the LTCF to provide an appropriate w/c including specialty constructed and specially sized chair if needed". If the patient was in the fee-for-service program, they would have access to custom seating wheelchair. This is an example of what happens when FFS and MCP policy is not consistent.

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

OAMES: *Using the assessment function noted above in question 9 would create a framework of feedback from beneficiaries and prescribers for understanding access to care and the quality and effectiveness of that care. This is turn could provide ODM with examples (actual patients) to review studying their use of services across the healthcare sector spend in the Medicaid managed care program. This would provide a more comprehensive understanding of utilization and identify problems that may have led to spending in other sectors that should not have occurred but were the result of access issues.*

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

OAMES: *The association has promoted the use of ODM's online complaint form. It is linked on our website, mentioned in member bulletins and highlighted by ODM staff at OAMES bi-annual Medicaid training seminars since the form was first created. However, while the form has been useful in limited cases, overall there is great reluctance by our members to use it fearing backlash from the specific managed care plan that they are reporting on. In other words, it's better than not having any option but it's not ideal.*

Provider Support

Standardization across managed care plans

13. Provide suggestions about how ODM could promote greater consistency of prior authorization requirements across managed care plans (e.g., requiring all managed care plans to use the same state-developed prior authorization form, or having the state establish which services can/cannot be prior authorized), including the pros and cons, potential barriers, and ideas for addressing those barriers.

OAMES: *This is a huge issue for the HME community. By allowing varied policies between the fee-for-service program and each of the five managed care plans, it's created significant hardship and confusion for the HME provider, prescriber and consumer. It is especially problematic due to patient migration frequency and the "rental" component of a significant portion of the HME benefit. OAMES position is that MCPs should follow OAC rule 5160-10-01 which provides a consistent, public and routinely vetted policy for determining best practices in prior authorization parameters based on medical necessity. If ODM will not require MCPs to follow the state's rule, we recommend MCPs do the following:*

** Prior Authorization rules must be consistently implemented from plan to plan by specific HCPC as defined by prevailing ODM requirements, unless the MCP PA requirements are **less** restrictive than ODM. Today, some plans base PA policy on arbitrary dollar amounts which has no correlation to medical necessity which is a far more logical metric to establish PA.*

** PA rules changes must be published no less than 90 days in advance of any effective date and must include a published 30-day provider comment period to ODM Managed Care section.*

** PAs must be able to be backdated to start of care when providers request PA at start of care but time lag exists from MCP to provider for approving a PA request.*

** PAs must be backdated to the MCP effective start of care date for any patient who changed plans without notice to the DMEPOS provider.*

** Approved PAs for a specific beneficiary should be accepted across all MCPs once appropriate medical necessity has been established by the current MCP.*

14. Are there certain other functions or processes (e.g., provider oversight, quality measures, reporting)

that should be standardized across managed care plans? If so, please identify:

- The function and how the function should be standardized
- The pros and cons of standardizing the function
- The potential barriers to standardizing the function and ideas for addressing them

OAMES: *The managed care DME benefit (coverage, processes, forms, work-flows etc. that are dictated through OAC rules) should be standardized to ensure equitable access to HME services for all Medicaid recipients in the fee-for-service as well as the managed care plans given the ebb and flow of patient migration as well as the "rental" nature of the HME benefit. After years of experience operating to the contrary, OAMES has revealed and shared access problems for patients and extreme operational difficulties and inefficiencies for providers and prescribers. Today's managed care environment actually hinders, not fosters, innovation in the HME benefit and prevents constructive work between OAMES, ODM and MCPs to develop delivery models based on care management programs that would improve health outcomes. It's created a setting where an MCP is permitted to contract with one HME provider for the entire state (sole source contracting) which appears to be based largely on geographic coverage (a provider must serve the entire state), an irrelevant metric for achieving care outcomes. This model segregates, not coordinates, patient services. It's a model that favors the plan, not the patient, and is raising concerns well beyond Ohio's borders as well. Putting these critical contracting decisions in the hands of the managed care plans has shifted focus from the input of diverse stakeholders achieved under the state's transparent regulatory process to shareholders behind closed doors. This removes genuine collaboration and creative conversation that's essential to elevating and strengthening the benefit. This might be a bitter pill to swallow if significant savings were achieved and difficult financial decisions were needed to be made by the State. However, without objectively evaluating these contracts, that remains unproven given the difficulties they present to care coordination.*

As a condition of contracting for Ohio's Medicaid patient populations, an MCP must, at minimum, follow the published, prevailing OAC medical necessity and coverage rules for DMEPOS contained in chapter 5160-10. MCPs must consistently apply the ODM standards for supporting medical documentation, proof of delivery, certificates of medical necessity forms and completion requirements, and appeal and review processes as published in the prevailing OAC rules 5160-10. When no coverage rule exists from ODM, the MCP must do the following:

- ** Publish its own coverage rule and make those rules available in advance to providers in an accessible format (Website Provider Portal)*
- ** Identify and provide Website Provider Portal access for any external medical necessity databases they use to adjudicate DMEPOS claims (or any other health sector claims)*

Communication about policy updates

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

OAMES: *Publish, post on the MCP's website and maintain an updated "Issues List" with dates of resolution for any system configuration issues that affects five or more providers. We understand this is a practice today between the MCPs and ODM but the provider community is out of the loop. For example, when MITS was being launched years ago, ODM maintained an "update" section on the ODM MITS home page. This was linked from OAMES website, news items routinely pushed to the membership when they developed, referenced at training seminars and became a central source for news that minimized confusion and eliminated countless one-on-one emails/calls for ODM and OAMES when issues arose.*

Support for administrative requirements

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

***OAMES**: The association has hosted bi-annual training seminars with the Ohio Department of Medicaid for decades and most recently, Medicaid managed care programs have joined in these educational events. This forum has fostered communications, provided a forum for trouble-shooting issues and provides an excellent networking opportunity for the staff of ODM, the MCPs and Ohio's HME providers to connect twice a year and get updated and collaborate on solutions. We continue to work with ODM and the MCPs to improve the programs and have supplemented these member forums with meetings and teleconferences as needed with MCPs and Department staff. We find there is a general lack of knowledge from the MCP representatives about the HME sector; the policies, coding, billing practices and more and having qualified staff available for guidance from the manager care companies is imperative. This on-going communication is critical for all parties to better serve Medicaid recipients.*

Data sharing

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

- What data do providers want access to that they do not have access to today; how would providers use that data?
- What is the most effective way of providing data to providers?
- Are there barriers to providing the requested data; how could those barriers be overcome?
- How could data be shared and used by providers that have limited resources and technology?

***OAMES:** We support greater transparency and public accessibility to better track how policy decisions are impacting spending trends, utilization and patient's experiences. OAMES has long partnered with ODM's Policy staff in using data to determine weaknesses in the HME benefit's policies and processes to ensure maximum program integrity. This has typically been done proactively by OAMES making the data request and working with Policy to discuss specific issues that develop. For example, low reimbursement for certain items may be causing an access issue (we developed modifiers to reimburse for custom tracheostomy tube codes in 2016), lack of specificity in coverage rules may be risking over-utilization (we clarified one-month only could be dispensed in incontinence rule in 2011). Tracking a patient's consumption of services through the continuum of care is critical for responsible management of the State's resources. Routinely (once a year?) pulling that data and having a "summit", a collaborative discussion possibly at the Medical Care Advisory Committee level, would bring stakeholders together who share the risk of the program's success to better understand their role in the bigger picture.*

Workforce development

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

***OAMES**: We understand that there is a tremendous shortage for private duty nurses who are needed in the specialty, highly complex care settings. We would be open to working with ODM to increase access to*

these clinicians in order to improve access to homecare; possibly partnering with the nursing community to develop curriculum at Ohio's community colleges unique to the homecare setting.

Other

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

OAMES: *We also propose to establish an HME Advisory Group comprised of designated representatives of each of the MCPs, OAMES and ODM Policy, Clinical Operations and Managed Care Oversight staff to meet at least twice annually to review and address issues as needed, including but not limited to appropriate beneficiary access, inconsistencies in medical policy, variances in claims adjudication requirements, proposed changes and performance trends. This could be replicated for other healthcare sectors as well to ensure a regular, constructive dialogue is maintained for communication and education.*

Benefits and Delivery System

Value-added services

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

OAMES: *We believe there is a proactive role that OAMES members within a specialty group could assist in the discharge process from the hospital to the homecare setting. We were involved briefly in the NICU project in 2016 involving the Ohio Perinatal Quality Collaborative and others to improve the transition of complex children to the homecare setting. Most of Ohio's children's hospitals are members of OAMES and we could develop a task force with ODM and MCPs focused on this conversion to support parents and families. HME providers bridge the hospital and homecare setting, knows the landscape ahead for these patients and could play a critical, collaborative role with other medical professionals to provide guidance and ensure minimal issues that jeopardize setbacks and readmissions.*

Care Coordination/Care Management

Care coordination/care management

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

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

OAMES: *Prohibit sole source for HME products or services. This restricted approach leads to fragmentation of care, the complete opposite of managed care that by design, is attempting to streamline and improve care coordination. If a patient has a complex medical condition, they will likely need a variety of HME products and services. For example, this may include various medical supplies, a hospital bed, oxygen therapy and a custom power wheelchair. If sole source contracts were to continue being implemented (there are three in Ohio Medicaid today – two for medical supplies, one for respiratory), a*

patient may need services from four different HME providers. We've seen the difficulty of this disjointed approach under the Medicare competitive bidding program. This greatly complicates the job of the case manager/care team, physicians and their administrative staff, the HME provider, the consumer and their caregiver. Furthermore, it reduces choice for prescribers and patients. This isn't about preference but actual medical need to find the best qualified HME provider for the patient's age and medical condition, brand toleration and other clinical and logistical criteria. Lastly, it's bad for Ohio's communities – it disrupts, or altogether eliminates, access to local providers which eventually puts local jobs at risk.

Sole source has been sold by its few proponents as saving money, reducing fraud and abuse and improving patient satisfaction. OAMES strongly questions the premise of those claims and has provided evidence to refute them. We urge the Department to assess the current programs in place before additional restrictive contracts move forward and use the re-procurement process to determine if these contracts make sense for all affected, most importantly the patients. We also strongly recommend that the oversight not be self-assessed by either the provider or MCP, but be done directly by ODM.

Cross-system collaboration

31. How could coordination of services/programs managed by partner state agencies be improved? Include your recommendations for the role of the state agency, state agency case manager, managed care plan, provider, and individual enrolled in a managed care plan.
    OAMES: *The HME provider may be in a position to aid in the improvement of cross-system collaboration. Given the HME provider is in the Medicaid consumer's place of residence, we have a unique perspective on their lifestyle, home situation, living conditions, family dynamics, etc. This may present an opportunity to expand the assessment role of an HME provider for these individuals and support the home health nurses if they are involved. A coordinated tracking tool used by HME providers to report back to ODM and other agencies that may be providing services to these individuals could be a supplemental role for coordinating all services through the various points of delivery.*

General Feedback

38. If you could change one thing about the current Medicaid managed care program, what would it be?
    OAMES: *Change the mindset that reducing competition in the managed care environment by implementing sole source contracts for HME services is an innovative care delivery model. To objectively and definitively evaluate that position, we urge ODM to:*
    - *Access the impact on the Per Member Per Month expenditures paid by ODM to the MCP from the implementation of a sole source agreement across all health sectors. There are three contracts in place: 1) UHC supplies contract (July 2017); 2) Buckeye supplies contract (March 2019) and 3) UHC respiratory contract (transitioning now, scheduled October 2019).*
    - *Delay the implementation of any additional sole source contracts until analysis has been conducted to determine whether a discounted contract on the least costly sector (HME benefits) has unintended consequences on spending in other higher cost health sectors (pharmacy, physician, hospital, etc.).*

    If the State of Ohio does not benefit financially from such arrangements, we question the strategic value for allowing them, especially given the impact on consumers and prescribers in the Medicaid managed care program.

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

OAMES: *We would welcome the opportunity to discuss modernization of the home medical equipment services benefit in ODM's managed care program and being a national leader in this movement for Ohio by collaborating with the Department to ensure methods of payment innovation as long as the minimum standards of OAC 5160:10 continue to be met. Since payment for HME services flow from ODM to the MCP, acceptable payment innovation models would essentially be owned by ODM and incorporated into OAC 5160:10. Beneficiary feedback, prescriber feedback and PMPM impact should be assessed by ODM to insure beneficiary access to medically necessary services and cost effectiveness of the Innovative Payment Program. Examples may include patient-centered initiatives such as:*

* *Reducing administrative burdens for prescribers and providers, resulting in lower costs;*
* *Investing in HME as lower cost service (by increasing payments, max quantities or other incentives) to reduce use of higher cost services in other health sectors;*
* *Establishing a creative risk-share payment program to reward quality patient care;*
* *Developing a quality initiative program for high-risk sectors to reward outcomes;*
* *Introducing innovative policies and technology enhancements to replace outdated delivery models or care standards to reduce overall spending in Medicaid.*