



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 inquiries.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

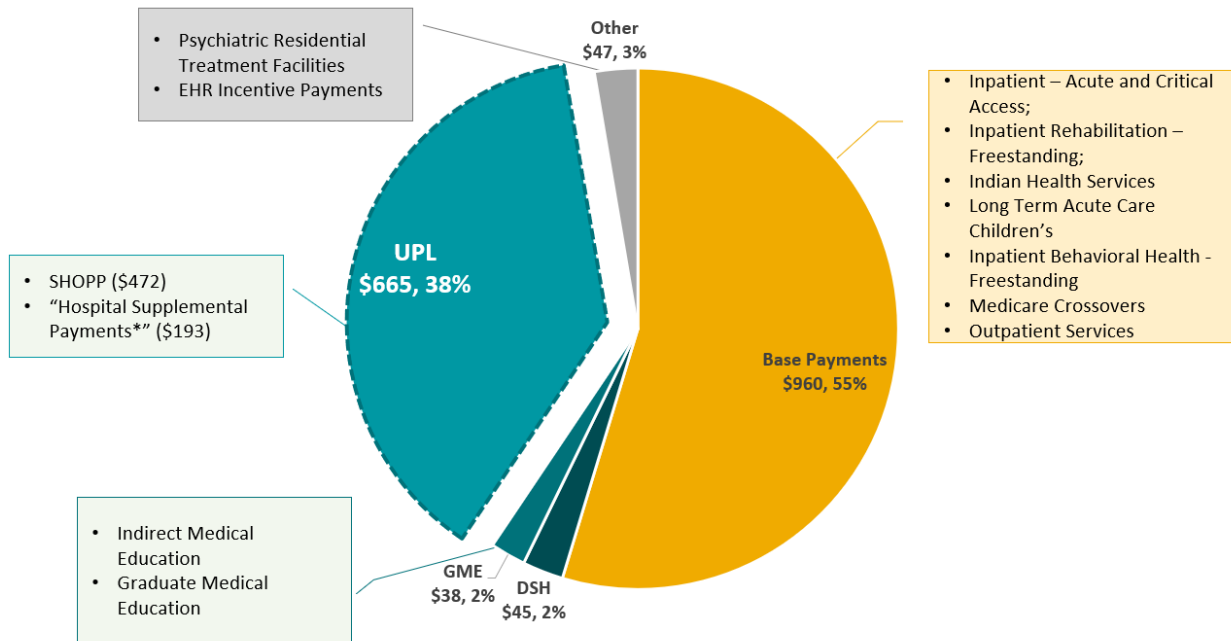
Preserve Value of Supplemental Payments. Under the current Medicaid payment methodology, the state makes an array of supplemental payments to hospitals, including Disproportionate Share Hospital (DSH) payments; Graduate Medical Education (GME) payments; and the SHOPP and Teaching Hospital Reimbursement 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

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.

¹⁶ Centers for Medicare & Medicaid Services, "Letter to Kansas Department of Health and Environment." January 13, 2017. Available at: <http://www.khanet.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 overcome 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
President
Oklahoma Hospital Association

²⁴ "Medicaid Managed Care: Lots of Unanswered Questions (Part 1)," Health Affairs:
<https://www.healthaffairs.org/doi/10.1377/hblog20180430.387981/full/>