Delaware Healthcare Association

*Wayne A. Smith*
*President & CEO*

August 13, 2021

Mr. Stephen Groff
Director
Delaware Division of Medicaid & Medical Assistance
1901 N. Du Pont Highway, Lewis Bldg.
New Castle, Delaware 19720

**Re: Feedback on Managed Care Organization Procurement**

*Alfred I. duPont Hospital for Children*
Mark Mumford,
Executive Vice President
Chief Executive,
Nemours Delaware Valley Operations

*Bayhealth*
Terry Murphy,
President & CEO

*Beebe Healthcare*
David A. Tam,
MD, MBA,
President & CEO

*ChristianaCare*
Janice E. Nevin,
MD, MPH
President & CEO

*TidalHealth Nanticoke*
Penny Short, MSM, BSN, RN
President & CEO

*Saint Francis Healthcare*

*Wilmington Veterans Affairs Medical Center*
Vincent Kane
Director

*Delaware Healthcare Association*
Wayne A. Smith
President & CEO

Dear Director Groff,

Thank you for the opportunity to submit comments on the upcoming Medicaid Managed Care Organization (MCO) procurement. The Delaware Healthcare Association, representing hospitals and health delivery systems in Delaware, respectfully requests that you consider the following recommendations to better serve Medicaid members and the providers that care for them.

**Technology and Innovation to Improve Member Experience**

Healthcare has changed drastically in the last few years and more innovation can be anticipated. DHA requests that the Delaware Division of Medicaid and Medical Assistance (DMMA) ensure that the MCOs adopt the latest medical break-throughs and innovations into their policies and processes to improve member health and experience.

1. Ensure comprehensive coverage and reimbursement for telehealth and other remote forms of healthcare delivery. The COVID-19 Pandemic rapidly increased the number of people who have utilized telehealth services proving its usefulness. Moreover, telehealth is an excellent way to provide care for underserved populations for which barriers to access are formidable.

2. Incorporate Innovations that Promote Quality Care and Patient Experience into plans. Delaware hospitals provide outstanding care and value and are continually striving to provide the best possible patient experience. Innovative new programs, such as hospital-at-home, look to improve outcomes and reduce costs.

3. It is extremely important for health plan and providers to work together to improve health status. To this end, DMMA should require health plans to share the data that they have collected with physicians and facilities to better



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understand the areas where resources are needed and clinical services should be developed.

4. Require that the MCO must have online portal capabilities for claim reconsiderations and document submission. When an MCO does not have this capability, as is the case with one of the current MCOs, records are sent via mail and can get lost or misplaced, delaying resolution for the providers and the patients.

**Improving Operations and Accountability**

The MCOs must be able to quickly resolve issues with providers. DMMA should consider the following recommendations to improve operations and accountability.

5. Initiate monetary penalties for internally created claim processing issues or denials when the MCO is unable to resolve them within 90 days. It is not uncommon that these issues linger for years. The hours it takes to resolve claims payment issues only add cost to the healthcare delivery system. The incremental costs are administrative and not clinically focused.

6. Require the MCOs to pay for inpatient days when they are unable to place a medically-cleared patient into a sub-acute facility because they have no beds available or an inadequate network to place the patient.

7. Require the disclosure of all third-party claim edit or audit companies used by the MCOs in their claims adjudication and review processes to help providers better understand the claims environment they may be entering.

8. Require the MCOs to make annual Current Procedural Terminology (CPT)/coding updates by the Centers for Medicare and Medicaid Services (CMS) effective date for the codes. Historically there has been a lag, sometimes as much as 5-6 months for the MCOs to make the updates.

9. Require the MCOs to resolve their audits, internal or via a third party, within 45 days of receiving the necessary records. Furthermore, failure to do so within that timeframe should require the payment of interest at the current Federal rate used by CMS.

10. Require the MCOs to have rates loaded into their claims adjudication system prior to the effective date to prevent underpayments and the subsequent reconciliation that is required.

11. Require the MCOs to use the Division of Medicaid and Medical Assistance (DMMA) list of non-emergent diagnosis codes for emergency department visits and not a combination of the DMMA list and a confidential proprietary list. This would create consistency throughout all the Medicaid plans.



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12. Require the MCO to identify the other possible primary insurance for a patient when the communication is sent from as the result of a retrospective coordination of benefits review (based on receiving a file from the State or another third party).

**Behavioral Health Services**

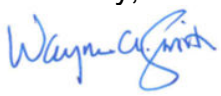
Delaware's behavioral health hospitals care for some of Delaware's most vulnerable individuals. We encourage DMMA to ensure the future MCOs support Delaware's behavioral health hospitals in caring for those in need mental health and substance use disorder treatment.

13. MCOs should better understand the American Society of Addiction Medicine (ASAM) criteria around paid bed days and length of stay to avoid denials when a patient needs care.

14. Provide a professional service fee from Medicaid in addition to the inpatient day rate for Medicaid patients.

Thank you again for the opportunity to provide feedback and recommendations for Delaware's managed care program.

Sincerely,



Wayne A. Smith



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