Factors to consider when presented with a request for sole source contracting or preferred provider contracting – exclusive of pilots, waivers, or payment innovation models.

DME or Specialty services

Factors	Comments
Stated purpose	Sole source agreements or narrow networks can be potentially destructive in a free market environment. The number of sole source or narrow network programs for assessment and study are relatively non-existent. Historical evidence of these types of agreements is difficult to obtain across all health sectors and throughout the country. In the three agreements recently implemented in Ohio, I'm not aware of any predetermined baseline data performance measures to determine whether a sole source agreement was implemented to reduce impactful spending for ODM, increase beneficiary access, improve quality or address a specific patient population or at risk patient group. At a minimum, before a sole source or narrow network program is implemented an agreed upon baseline performance measure(s) should be established. The program can then be checked at various intervals to determine if the program is meeting its intended goals.
Number of competitors/suppliers	Should ODM define standards and procedures for an MCP to solicit bids? Should bids include provider qualifications including previous experience in implementing the scope and type of agreement developed? Should provider's financial strength and resources be assessed to insure that program objectives have a reasonable chance to be met? Should consideration be given to in state providers vs. out of state providers (business and commerce impact)? Should there be a defined exit plan insuring beneficiary needs will continue to be met should the MCP, the sole source provider or other market factor disrupt the continuation of services covered by the sole source agreement.
Regulatory hurdles for new market entrants	How does 42 C.F.R. 431.51, OAC 5160-58-03.2 or OAC 5160-41-08 apply to a sole source service model? Should an agreement like this be subject to Ohio's public posting, comment period and stakeholder vetting that exists now for Medicaid policy?
Preferred provider	Don't MCPs today have the ability to guide members to specific providers who meet quality, cost and service objectives of the MCP without a formal sole source construct? Appropriate definition of a preferred provider and designation of preferred provider status could be created in the MCP Member portal, for example. Certain established programs like the Medicare Competitive Bid program and the VA have

	already identified negative impact on beneficiary access with its limited provider programs.
Sole source	Do sole source agreements created unnecessary hardship around the silo effect of organizing care or services with multiple sole source specialty providers?
Member opt out	An "opt out" provision for specific reasons (including Member or Caregiver preference) would address any unintended consequences or burdens on Members, Caregivers and Prescribers. Measuring and capturing an "opt out rate" would also provide value in measuring the quality of services, the capability of the chosen provider and the effectiveness of the sole source program. Over time, if opt out rates are extremely low, a progression to a more restrictive sole source agreement could be considered.
FFS or MC or both	I'm struggling to understand that if a sole source agreement provides cost, access or quality improvements why an Insurance plan wouldn't use it for its FFS population before implementing in Managed Care.
Payment – per unit	Methods for measuring utilization trends in the targeted health service or sector should be established before implementation. Monitoring and measurement of "neighboring" health services should also be identified and captured. For incontinence programs for example, if per member utilization per month decreases, is there a related spike in other health sector spending? If utilization increases, is there a measurable decrease in other health sector spending? Should the affected patient population for incontinence be monitored for spikes in increases in UTIs reported or changes in pharmaceutical consumption pre and post sole source program?
Payment – per diem	How are payments outside of the traditional FFS methodology captured to insure ongoing and consistent assessment of utilization trends.
Payment – capitation	On capitated plans what method is to be used to identify the additional burdens and cost of program oversight? Are unintended costs considered for conditions like substantial weather catastrophes, provider bankruptcy or consolidation?
Payment – salary/flat rate	
Delivery method	Certain service delivery models are more appropriate for sole source agreements. Lower acuity services, Mail order or drop ship items that are not life supporting or sustaining may be more appropriate for narrow networks or sole source agreements. Fragmentation of services due to geographic service areas, rural communities or regionalization should be carefully considered.
Eligibility categories impacted	Are DODD Waiver patients and MyCare patients legislatively allowed to maintain patient choice? What kind of disruptions occur, what type of additional prescriber burdens are created and at what cost to ODM when patients are free to migrate from plan to plan, especially when each plan could have sole or extremely narrow provider networks.
Method for review and approval	ODM should establish a combination of stakeholders to review a sole source proposal, including prescriber, caregiver, health system and

	consider an open comment period from stakeholders before implementing programs of this type.
Factors monitored	Pre and Post Per Member Unduplicated Patient Utilization. Opt Out Ratios. Pre and Post PMPM costs. Identify other health sectors that could be affected by unintended consequences and measure those components for the specific beneficiary population moved into a sole source program.
Other	