Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care

Future Vision and Policy Considerations for Public Engagement

Prepared by: the Bureau of Health Services Financing

Louisiana Medicaid

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LOUISIANA DEPARTMENT OF HEALTH

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Executive Summary

The Louisiana Department of Health (the Department or LDH) is planning its third procurement cycle for the state's Medicaid managed care program. The program has evolved considerably since its inception in 2012, with services and enrollees added to the program year over year. Most recently, the state has experienced dramatic improvements in health metrics as a result of expansion enrollment in the managed care program. And, importantly, Medicaid enrollees are engaged in care: over 75 percent of Medicaid managed care enrollees eligible as a result of Medicaid expansion have visited a physician. Over 162,000 enrollees have received preventative care visits with a provider. More than 30,700 women have completed important screening and diagnostic breast imaging such as mammograms, MRIs and ultrasounds. Treatment has begun for almost 5,700 adults newly diagnosed with diabetes. More than 14,500 patients have been newly diagnosed with hypertension. More than 51,000 people have received mental health services. More than 15,800 people have been treated for substance abuse.

The Department's guiding principle with this upcoming procurement is the simultaneous pursuit of the "Triple Aim" of better care, better health, and lower costs. LDH will focus on improving the patient experience of care (including quality and satisfaction), improving the health of populations, and managing costs within the Medicaid managed care program. LDH will do so in collaboration with enrollees, providers, and high-performing health plans. The Department's procurement will be designed to find the best health plan partners to achieve this Triple Aim.

The Department continues to hear concerns about access to care for Medicaid managed care enrollees, as well as complaints from providers about the complexity of the program. The Department seeks to improve the managed care program further by focusing on enrollee health and provider satisfaction. As part of the procurement, the Department seeks ways to reduce paperwork for contracted managed care providers and increase clarity about what is covered by Medicaid health plans. LDH also seeks new and better ways to help more enrollees achieve their health goals and improve their wellbeing.

The Department plans to issue a competitive Request for Proposals (RFP) in early 2019 and execute new Medicaid managed care contracts with a limited number of selected bidders prior to an operational start date of January 1, 2020. These new Medicaid Managed Care Organization (MCO) contracts will represent the heart of the Department's vision for better care, better health and lower costs. As described in this white paper, LDH's approach emphasizes that successful bidders will reward providers for better care, improving enrollees' experience of the program, and making it easier for providers to participate in the program.

Compared to past procurements, the Department's expectations will be higher for successful bidders. The Department is looking for experienced MCOs with which it can partner to improve access to care, quality of care, and ultimately the health of Medicaid managed care enrollees in Louisiana. LDH is planning to increase requirements placed on contracted MCOs in terms of access to and use of primary care, the integration of physical and behavioral health care services, and the adoption of provider payment reforms to support delivery system

improvements. As part of the procurement process, the Department expects MCOs to bring greater focus on continuous quality improvement initiatives, program integrity, and improvements in health information technology.

The Department is in the policy development and information gathering stage for this future procurement and is taking unprecedented steps in public engagement. As you read this document, you will find key design elements and concepts based on the best available evidence from Medicaid managed care programs across the nation. We invite your review and look forward to your input. We greatly value your participation in this process.

LDH invites interested stakeholders to submit written feedback on the design elements presented in this white paper by April 17, 2018, 2:00 pm Central Daylight Time. To allow for oral comments, the Department will also hold public forums in March 2018 in various locations across the state as noted in this white paper.

Providing comments in response to this white paper will not prohibit interested parties from responding to any future procurements.

I. Introduction

a. Background

The Department is Louisiana's single state Medicaid agency with responsibility for administering the state's Medicaid and Children's Health Insurance Program (CHIP) programs. The Department's Medicaid managed care program is responsible for providing innovative, cost effective and quality health care to eligible Medicaid recipients. The current Medicaid managed care contracts expire December 31, 2019.

The state's Medicaid managed care program launched in February 2012. Over time, the Department has integrated additional services and populations into the program. Following a second procurement in 2014, LDH executed the current managed care contracts in 2015.

Today, the state contracts with five statewide MCOs to provide specified Medicaid benefits and services to eligible children and adults in Louisiana. For more information on the MCO contracts, click here.

Managed care enrollment in Healthy Louisiana stands at more than 1.5 million enrollees.

b. Vision for the Future of Louisiana's Medicaid Managed Care Program

As it moves forward, the Department will partner with enrollees, providers, and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (**better health**), enhances the experience of care for individuals (**better care**) and effectively manages Medicaid per capita care costs (**lower costs**).

More specifically, the Department will hold contracted health plans accountable for:

i. advancing evidence-based practices, high-value care and service excellence;
ii. supporting innovation and a culture of continuous quality improvement in Louisiana;
iii. ensuring enrollees ready access to care, including through non-traditional means such as medical homes and telehealth;
iv. improving enrollee health;
v. decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs;
vi. using a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address social determinants of health;
vii. reducing complexity and administrative burden for providers and enrollees;
viii. aligning financial incentives for plans and providers and building shared capacity to improve health care quality through data and collaboration; and,
ix. minimizing wasteful spending, abuse and fraud.

c. Organization of the RFP and Model Contract

LDH intends to issue the Managed Care RFP in early 2019. The procurement document will provide background information on Louisiana's Medicaid managed care program, the vision for the MCO program going forward, key priorities for the contract period, questions that bidders must respond to as part of their submission, and evaluation criteria. In addition, the Department will simultaneously post a procurement library including a data book, and attachments to the RFP. One of the RFP attachments will be a stand-alone Model Contract, which details the scope of work responsibilities of contracted MCOs. The Model Contract, incorporating the RFP and related proposal by reference, is the essence of the contracts to be executed between selected bidders and the Department. This approach to organizing the RFP and model MCO contract will allow for a cleaner organization and management of the contract on an ongoing basis.

II. Purpose of the MCO RFP White Paper

One of the key goals in publishing this white paper is to provide transparency with regard to the Department's objectives and possible design elements for the state's next generation Medicaid managed care procurement. LDH would like to obtain stakeholder feedback on major design elements that are under consideration. Interested parties are encouraged to provide written or oral feedback to this white paper as described in Section IV.

The descriptions and questions presented in this paper are merely proposals for the Department to consider when developing strategies to meet the Department's vision and objectives for its managed care program and are not final policy decisions on the part of the Department.

III. Select Policies in the MCO RFP and Model Contract

This section of the white paper includes a short description of the following 12 policy areas of interest to LDH as it develops its MCO procurement:

a. limit the number of statewide MCOs	g. improve care management/care coordination at MCO and provider levels
b. expect MCOs to operate as innovators to achieve the Triple Aim	h. increase focus on health equity and social determinants of health
c. enhance network adequacy and access standards	i. promote population health
d. invest in primary care, timely access to care, telehealth and medical homes	j. apply insights from behavioral economics to facilitate enrollees' healthy behaviors and choices
e. improve integration of physical and behavioral health services	k. improve approach to value-added benefits
f. advance value-based payment and delivery system reform	l. achieve administrative simplification

As noted below, LDH is interested in gathering feedback on specific questions related to each of these policies.

a. Limit the Number of Statewide MCOs

Louisiana's next managed care procurement will be a competitive procurement designed to enable the Department to selectively contract with a limited number of statewide Medicaid plans accredited by the National Committee on Quality Assurance (NCQA). The RFP and ensuing Medicaid MCO contracts will be designed to support delivery system transformation to achieve the Triple Aim: better care, improved health, and lower costs.

Selected MCOs will operate under statewide, full-risk contracts and cover a comprehensive set of Medicaid services for all managed care eligible populations in Louisiana. For efficiency and administrative simplification, and to better enable plans to respond to increasing MCO expectations, the Department is open to considering a reduction from the current number of contracted MCOs as part of the upcoming procurement.

The Department envisions significant changes in the evaluation of proposals, the future MCO contract scope of work, and the accountability of selected health plans to improve outcomes for enrollees, providers and taxpayers. The Department's efforts with the next generation of Medicaid managed care will further integrate care delivery systems, hold MCO contractors more accountable for performance, align incentives to improve health outcomes and better manage limited resources.

Request for input: Please share recommendations on the maximum number of statewide MCOs the state should contract with for Medicaid. The state currently contracts with five Medicaid MCOs. For more information on the Department's MCO contracts, click here.

b. Expect MCOs to Operate as Innovators to Achieve the Triple Aim

Achieving LDH's vision requires state policies and procurements that promote a culture of learning. The Department does not seek bidders that will merely mimic Medicaid fee-for-service rates, state plan policies and procedures. Preferred MCOs will be willing to engage in and support continuous quality improvement on administrative, clinical, and efficiency metrics. Successful bidders must work with the Department and providers to innovate, including to reduce program complexity, administrative burden, and unnecessary costs; and to improve care coordination, chronic disease management, and the provision of integrated care addressing physical health and behavioral health needs. Successful bidders will evaluate the effectiveness of their program interventions and adjust as necessary to achieve performance excellence for Louisiana Medicaid enrollees, providers, and taxpayers.

During the next managed care contracting cycle, the Department will contract with MCOs to advance evidence-based practices, quality care and service excellence. For example, selected bidders might adopt strategies from Choosing Wisely (www.choosingwisely.org) that promote conversations between providers and patients to choose care that is:

- supported by evidence,
- not duplicative of other tests or procedures already received,
- free from harm, and
- truly necessary.

Request for input: Please share recommendations related to how MCOs could offer innovations to reduce program complexity, administrative burden, and unnecessary costs and to improve care and population health in partnership with providers and patients. Please share recommendations related to how the procurement could best advance evidence-based care and meet the Triple Aim.

c. Enhance Network Adequacy and Access Standards

Recently, the Department strengthened MCO network adequacy and access standards related to the type and geographic distribution of providers MCOs need to offer covered services. In addition, there are standards for timeliness and availability of appointments for certain types of care. A summary of MCO network requirements for different types of providers and services is included in the Provider Network Companion Guide at the following website: http://ldh.louisiana.gov/assets/docs/BayouHealth/CompanionGuides/ProviderNetworkCG.pdf

LDH will continue to enhance MCO network adequacy and access standards as well as reporting and oversight mechanisms for ensuring MCO compliance with these standards. MCO provider networks will be assessed and scored regionally, both during the procurement and as part of ongoing MCO contract monitoring by LDH, and with assistance from its External Quality Review Organization. Gaps in provider network adequacy, if any, must be addressed by selected MCOs during the readiness review period and as part of ongoing network development prior to enrollment. The Department may consider freezing auto-assignment of new enrollees or all enrollment for an MCO based on performance to core administrative, access, and quality measures to be identified in the RFP and model contract.

Successful MCO contractors will be required to maintain, monitor and manage their networks of providers. MCOs must demonstrate and assure the sufficiency of its network to meet the health care needs of enrollees for all covered services within expanded Department MCO network adequacy and timely access standards, and reporting requirements. For example, through a combination of RFP submission requirements and ongoing Model Contract requirements, successful MCOs shall clearly identify and address:

- Provider ratios for primary care providers (PCPs) and specialists, appointment availability surveys, geo-access analyses, and other information to demonstrate MCO's ability to meet network adequacy and time, distance, and accessibility standards.
- Strategies to maximize ready health care network access and availability for enrollees, including but not limited to availability of telemedicine or telehealth, e-visits, triage lines or screening systems or other technology used to enhance access to care.
- Methods for assessing health care needs of enrollees and their satisfaction with access to and availability of MCO covered services.
- PCPs not accepting new patients and how the MCO will work to increase the number and percentage of network PCPs accepting new patients without conditions/limitations.
- Procedures and time frames for making and authorizing referrals and prior authorizations if applicable within and outside its network.
- Addressing and improving access and availability in network gaps for provider specialty exceptions, if applicable.

Request for input: Please offer suggestions for changes in the next Medicaid managed care procurement to enable the Department and its contracted MCOs improve and ensure enrollee ready access to covered services, especially in rural and underserved areas.

- What types of reporting and monitoring of MCO provider networks would you recommend to better assess the adequacy and timeliness of access to care for Medicaid MCO enrollees?

- What specific delivery and care coordination approaches might MCOs employ to meet the needs of enrollees in rural and underserved areas?
- How might the Department improve its evaluation of the adequacy of MCOs' response to enrollee health care needs in rural and underserved areas?
- Are there deficiencies in MCO provider networks in certain regions/parishes and/or covered services that LDH should specifically address in the managed care procurement?

d. Invest in Primary Care, Timely Access to Care, Telehealth and Medical Homes

LDH seeks MCOs that will commit to investing in ready primary care access, and embrace practice transformation into medical homes. MCOs will be required to monitor and facilitate the timely availability of enrollee appointments with providers consistent with appointment standards established by LDH. The EQRO will work with Department to support in assessing MCO provider network compliance with appointment availability standards established by the model contract.

Successful bidders must participate in initiatives to develop, implement and continually improve actionable reports for PCPs that support activities to improve population health management. During the contract period, MCOs must report to LDH and PCPs on changes in inpatient utilization, emergency department utilization, physician services, outpatient utilization, prescription drug utilization; and selected health outcomes that are pertinent to the population served.

Successful bidders will work with LDH and stakeholders to reduce fragmentation of service delivery and create a more effective health care system.

Request for input: Please suggest ways in which successful bidders might demonstrate initiatives that would meet the Department's goal to improve enrollee access to primary care, and the Department's desire for increased practice transformation into medical homes.

- How might the Department encourage or require contracted MCOs use of telemedicine or telehealth, and e-visits to improve enrollee access to care?
- How might the Department encourage or require MCOs to adopt effective triage lines or screening systems, or other technology to help improve access and coordination of care?

e. Improve Integration of Physical and Behavioral Health Services

LDH recognizes the importance of integrating both physical health and behavioral health services to effectively address enrollee needs and improve health status. Providers are essential partners in the delivery of effective and efficient physical and behavioral health care services. Successful bidders must agree to work with LDH

and providers to develop initiatives to better integrate services for enrollees and to provide incentives to support behavioral health integration.

Successful MCOs must consider both the behavioral health and physical health care needs of enrollees during network development and ongoing network management. MCOs must develop specific strategies to promote the integration of physical and behavioral health service delivery and care integration activities such as:

- Incentivizing providers to co-locate physical and behavioral health services,
- Support for PCPs who screen for behavioral health issues and treat mild to moderate cases,
- Implementing care coordination and care management best practices for physical and behavioral health care,
- Providing the appropriate level of care management/coordination of services to enrollees with co-morbid physical health and behavioral health conditions and collaborating on an ongoing basis with both the enrollee and other individuals involved in the enrollee's care, and
- Ensuring continuity and coordination of physical and behavioral health services and collaboration/communication among physical and behavioral healthcare providers.

Request for input: Please offer suggestions for key aspects of behavioral health and physical health integration and how the Department could ensure that successful bidders offer and support improved integration of behavioral health and physical health care delivery for enrollees in this upcoming procurement. What specific network development, care delivery and care coordination approaches might the Department encourage or require MCOs to employ to better meet enrollees' behavioral health needs?

f. Advance Value-based Payment (VBP) and Delivery System Reform

LDH is expanding its VBP efforts within its Medicaid managed care program. VBP involves moving away from traditional fee-for-service (FFS) payment at the provider level and implementing a broad set of payment strategies intended to improve quality, outcomes and efficiency by linking financial incentives to performance at the provider organization level. In VBP, providers are paid – at least in part – based on "value" components, not solely on "volume." Examples of VBP models include, but are not limited to:

- Medical homes
- Pay for performance
- Shared savings/risk, including with Accountable Care Organizations (ACOs)
- Episode-based care
- Primary care capitation

For more information on value-based payments and program design considerations for Medicaid ACOs, please see the following resources:

- https://www.chcs.org/media/VBP-Brief_022216_FINAL.pdf
- https://www.chcs.org/media/Program-Design-Considerations-for-Medicaid-Accountable-Care-Organizations.pdf

Over the contract period, LDH will increasingly require its MCOs to implement VBP strategies that reward providers for improving quality and efficiency of care for Medicaid enrollees. As currently being considered by LDH, in some cases, MCOs will be required to implement VBP as specified by LDH, while in other cases, MCOs will have flexibility to select VBP options from among state-approved models or strategies. Requirements to meet specific VBP thresholds linked to MCO withhold criteria will encourage and incentivize MCOs to expand the use of VBP beyond the state-defined and required models to improve performance in areas/measures targeted by LDH.

As part of the procurement, LDH is considering requiring contracted MCOs to:

- Report on implementation of alternative payment models (APM) based on the Health Care Payment Learning and Action Network (HCP-LAN) framework, consistent with specific state requirements for MCOs to increase VBP usage over time to reward value and improve care,
- Develop and implement a VBP or enhanced fee schedule for primary care providers meeting certain quality criteria consistent with LDH MCO performance measures, and
- Contract with local, provider-based Accountable Care Organizations (ACOs) consistent with timelines and standards to be specified in the procurement. Bidders must demonstrate a commitment and ability to utilize qualified ACOs to care for Medicaid enrollees beginning with the effective date of the new MCO contract.

LDH is considering requirements within the MCO contract related to minimum criteria for Medicaid ACOs as well as criteria related to MCO contractual arrangements with ACOs. An ACO will be defined as a group of PCPs and other key providers that agree to work together to improve outcomes and contain cost, in part by leveraging patient-centered medical home activities and coordinating care across patient population. ACOs will be paid based on the value provided to attributed Medicaid enrollees rather than solely for the volume of care delivered. ACOs will be designed to bring both 'accountability' and 'rewards' to the provider level. ACOs will give providers across the continuum of care more responsibility, and reward providers for achieving improved health care outcomes and reducing low-value care and unnecessary utilization.

LDH anticipates defining specifications that address the following components of Medicaid ACOs in Louisiana: 1) ACO governance/composition, 2) ACO payment model, 3) ACO performance measurement, and 4) respective roles of the ACO, MCO, and LDH.

Request for Input: Please offer suggestions on how contracted MCOs can best promote adoption of new payment methodologies that reward providers for the value they create as opposed to fee-for-service methodologies that reward providers for the volume of services they provide.

- Please comment on provider readiness to participate in VBP arrangements, including ACOs, by 2020. What support should LDH or its MCOs make available to providers?
- Please suggest policies for the MCO model contract related to Medicaid ACOs criteria for ACOs, and/or the respective roles of the ACO, the MCO and LDH.

g. Promote Population Health

Population health management includes an emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities.

MCOs must promote enrollee engagement and responsibilities by undertaking person-centered initiatives that improve access to behavioral health, dental care, community health workers, patient navigators, and health promotion and prevention programs delivered by community-based organizations, or social service programs from the clinical setting.

As part of the procurement, LDH intends to require MCOs to develop a population health strategic plan during the first year of the contract. At a minimum, the strategic plan should include the MCO's approach to using data to identify population health needs and implementing evidence-based strategies across populations to improve the overall health of the population.

Request for input:

- What requirements should be placed on MCOs in terms of utilizing a population health approach to care delivery?
- What are the key aspects that should be included within a population health strategic plan?

h. Improve Care Management/Care Coordination at MCO and Provider Levels

As part of the next procurement, LDH plans to define care management as a set of person-centered, goal-oriented, culturally relevant and logical steps to assure that an MCO enrollee receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links enrollees to services as necessary across providers and settings, including medical, behavioral and psychosocial service needs. MCOs will be required to provide care management to high and rising risk populations based on a variety of factors including the highest cost enrollees, and those with targeted needs based on use of the emergency department, hospital transitions of care, special health care needs or chronic conditions, behavioral health conditions, and social determinants of health.

At a minimum, LDH is considering requiring MCOs to provide the following care management functions: 1) Health Risk Assessment for all enrollees, 2) Short term care coordination, where appropriate, and 3) Intensive Care Management, where appropriate.

In addition, as part of their care management programs, MCOs will be required to invest in targeted, evidence-based use of community health workers, home visiting services, and other strategies to improve care and advance population health.

The community health worker approach undertaken by the University of Pennsylvania Health System is referred to as the IMPaCT™ model. In this approach, community health workers provide tailored support to help high-risk patients achieve individualized health goals. For more information on the UPenn approach see: http://chw.upenn.edu.

For additional information on key considerations for integrating community health workers into complex care teams see the following publication: https://www.chcs.org/media/CHW-Brief-5-10-17.pdf

Care management must be provided in a person-centered way, with the patient's identified goals and needs at the center of the care. The care team should be multi-disciplinary and integrate providers from across the continuum that are part of the patient's care. Family members should be included in the care planning process.

MCOs must coordinate their care management with care management that occurs at the provider level, and support, rather than duplicate those care management supports. MCOs must identify provider practices with embedded or shared care managers and establish standardized work processes between MCOs' care management staff and the practice care managers to promote coordination of services and avoid duplication of services. Such work processes must include establishing a single point of contact between the health plan and an embedded care manager.

Request for input: Please offer suggestions for the RFP and/or model contract functions and elements related to improving care management and coordination at both the MCO and provider levels. In addition, please provide your opinion on whether MCOs should be required to employ, support, and/or utilize Community Health Workers for certain populations and care management interventions? Please elaborate.

i. Increase Focus on Health Equity and Social Determinants of Health

In the next generation managed care contracts, MCOs must collect and analyze data to systematically stratify enrollees to ensure enrollees with increasing health risks and social needs are identified for and connected to applicable population health management services. MCOs must utilize information such as claims data, pharmacy data, and laboratory results, utilization management data, health risk assessment results and eligibility status to address health disparities, improve community collaboration, and enhance care coordination, targeted interventions, and care management services. In addition, MCOs will be required to collaborate with high volume providers to develop, promote and implement targeted evidence-based interventions for subpopulations experiencing health disparities such as:

- Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.
- Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.
- Persons who are eligible for Medicaid based on an eligibility designation of disability.
- Persons with chronic conditions, such as diabetes, obesity and cardiovascular disease.
- Persons in need of complex care management, including high-risk enrollees with dual behavioral health and medical health diagnoses.
- People with Special Health Care Needs (PSHCN).

Request for input: Please offer suggestions for ways that LDH can utilize the upcoming managed care procurement to increase MCO focus on social determinants of health and improve health equity. For reference, see the following link to a report on "Enabling Sustainable Investments in Social Interventions: A Review of Medicaid Managed Care Rate Setting Tools," http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting.

j. Apply Insights from Behavioral Economics to Facilitate Enrollees' Healthy Behaviors and Choices

Behavioral economics recognizes that human behavior is irrational and can be influenced, or nudged, through the presentation of choice, framing of messages and

design of financial rewards. Proven behavioral economics principles point to new methods for facilitating, engaging and helping enrollees across all payer types engage in healthy behaviors. LDH is exploring how best practices in healthcare design, through the lens of behavioral economics, can be applied in Medicaid to drive behavior change, leading to improved health, closed care gaps, and optimized spending.

MCOs will be expected to respond to LDH recommendations for behavioral economics-based approaches to optimize the use of enrollee incentives to facilitate healthy behaviors and choices.

For more information on behavioral economics, please see the following websites:

- http://chibe.upenn.edu/
- http://nudgeunit.upenn.edu/about

Request for input: Please offer suggestions for how best to incent Medicaid MCO enrollees for healthy behaviors and medical compliance and/or share experiences applying behavioral health economics in other insurance settings.

k. Improve Approach to Value-added Benefits

MCOs under contract with the Department currently offer a variety of value-added benefits and services to enrollees and providers at no additional cost to the state. For more information on the value-added benefits currently offered by each MCO see: http://ldh.louisiana.gov/assets/HealthyLa/Resources/224071_LAEB-COMPCHART_PROOF-4.pdf

As part of the next procurement, the Department anticipates restricting the number and type of value-added benefits that bidders can propose to offer. To simplify the managed care program for providers and enrollees, bidders may be required to select from among a limited menu of value-added benefits that they may offer. Bidders will not be asked to propose "value-added" provider benefits and services. The Department expects MCOs to incorporate value-added approaches for providers as part of their overall VBP strategies and approaches to reward providers for improved performance and value.

Request for input: Please offer suggestions related to whether and how MCOs should be able to offer value-added benefits and services at no additional costs under the next procurement. Please indicate whether specific comments apply to value-added benefits for enrollees, providers, or both.

l. Achieve Administrative Simplification

LDH will employ multiple strategies to address provider complaints related to the administrative burden from contracting with multiple managed care plans. For example, the Department will require MCOs to be more transparent with providers on their prior approval processes including their clinical criteria. LDH will require plans to utilize a common preferred drug list. MCOs will also be required to reduce

paperwork, be more accessible to network providers, and be more proactive in addressing common provider inquiries and complaints.

The requirement for simplified and single provider credentialing will eliminate the need for Medicaid providers to be separately credentialed by each health plan before contracting with them. In addition, the Department is considering expanding the requirement for MCOs to have meaningful provider participation beyond quality efforts and including provider and local stakeholder representation in their local governing boards and advisory committees of contracted Medicaid MCOs.

LDH is also seeking to have MCOs identify approaches for lessening the administrative burden and complexity of the program on enrollees.

RFP submission requirements and readiness reviews for new contractors will be designed to give LDH, providers, and other stakeholders more assurance that plans can and will meet the increased requirements of the next generation MCO contract. In the MCO Model Contract, LDH will include requirements and modifications focused on administrative simplification including meaningful provider engagement and enhanced claims processing standards.

Request for input: Please offer specific ideas for achieving the Department's aim for greater administrative simplification in its Medicaid managed care program by reducing the burden and complexity of the program for enrollees. In addition, the Department is interested in ideas to make the program less burdensome for providers by reducing paperwork, redundancies, and improving clarity of clinical criteria.

IV. Submission of Written and Oral Feedback

The Department welcomes feedback to the requests for input indicated in Section III above.

In responding to this white paper, commenters should clearly identify the question(s) to which they are responding. Commenters are not required to address all the requests for input and questions; commenters may provide their input on areas not listed in Section III above but that are relevant to the topics in this white paper.

Feedback on this white paper in general and these questions in particular may be submitted to LDH either in writing or orally in person. The Department will not be liable for any costs incurred by respondents in preparation of written or oral feedback to this white paper. All information received by LDH becomes the property of the Department and will not be returned to the sender. There will be no acknowledgement

by the Department of receipt of the information. Acceptance of feedback places no obligations of any kind upon the Department.

Written feedback should be submitted by April 17, 2018 via email to healthy@la.gov.

- The written submission should indicate the submitting organization and preferably be limited to no more than 10 pages. Faxed or mailed documents will not be accepted.
- All written comments submitted will become public documents.
- Written feedback must identify the individual or organization as follows:
    - Name of individual or organization:
    - If an organization, type of organization:
        - ☐ Health system
        - ☐ Provider organization
        - ☐ Consumer advocacy organization
        - ☐ Insurer
        - ☐ Other (please describe): _____
    - Region represented by organization:
        - ☐ Statewide
        - ☐ Region(s) (please list):_____

To solicit feedback in person, the Department will hold a series of Medicaid Managed Care public forums in various locations throughout the state as noted in the following table.

LDH Statewide MCO RFP Public Forums

Location	Date/Time	Host Site
New Orleans	March 8, 2018 6-8pm	Children's Hospital Conference Center 210 State Street New Orleans, LA 70118
Baton Rouge	March 14, 2018 6-8pm	Our Lady of the Lake Regional Medical Center Main Auditorium 5000 Hennessy Blvd. Baton Rouge, LA 70805
Lafayette	March 15, 2018 6-8pm	Lafayette General Hospital Administrative Office 920 W. Pinhook Rd. Lafayette, LA 70503

Location	Date/Time	Host Site
Lake Charles	March 16, 2018 11:30am-1:30pm	Lake Charles Memorial Hospital Sherman Conference Center 1701 Oak Park Blvd Lake Charles, LA 70601
Shreveport	March 22, 2018 11:30am-1:30pm	Willis-Knighton Health System WK Eye Institute 1st Floor Auditorium 2611 Greenwood Road Shreveport, LA 71103
Monroe	March 22, 2018 5:30-7:30pm	St. Francis Medical Center Conference Center 418 Jackson Street Monroe, LA 71201
Alexandria	March 23, 2018 11:30am-1:30pm	The Rapides Foundation Building 1101 4th Street Alexandria, LA 71301
Slidell	April 5, 2018 6-8pm	Slidell Memorial Hospital Founders Medical Office Building Conference Room – 1st floor (near rear entrance) 1150 Robert Blvd. Slidell, LA 70458

V. Conclusion

The Department thanks stakeholders in advance for their input and interest in the Medicaid managed care program and this white paper.

The Medicaid Managed Care procurement will be posted at the Department's web site (www.ldh.la.gov) in early 2019.

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov


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