Recommendations for Helping MCOs Operate as Innovators to Achieve the Triple Aim
We strongly support Medicaid managed care organizations (MCOs) playing an integral role in achieving the triple aim of better care, better health and lower costs. Our comments in this section will primarily focus on achieving the aim of better care, including improving the quality of patients' experience and satisfaction with their care, as we will provide recommendations for improving the health of populations and managing costs within the Medicaid managed care program later in our comments.

To improve the patient experience and quality of care for individuals, we strongly believe consumer engagement is integral to the design, implementation and oversight of Medicaid managed care programs. We believe patients will be actively engaged in their care if their direct experience and feedback is integrated at three levels: policy, delivery system and in the clinical setting.

- At the policy level, we believe MCOs should host regular public meetings with members to gather input on the design, implementation and oversight of the MCO, as well as include patient representation on implementation and oversight committees and provide ongoing appropriate training and support to participate meaningfully. Additionally, oversight committees can advise LDH on quality measures and performance reviews of MCOs and make recommendations on contract provisions.
- At the delivery-system level, we believe there should be patient representation on MCO governing boards, governing board membership should reflect the community served and include adequate member representation. Member representation needs to be diverse as individual consumers cannot represent the views of an entire community. In addition, the ratio of member representation to provider or other stakeholder representation should be at least equal. Consumer members could be consumer advocates and/or consumers enrolled in the MCO or a family member or caregiver.
- At the clinical level, we believe MCOs should incentivize providers to use shared decision-making tools, patient engagement measures and individual care plans in their practice, as well as actively engage patients and caregivers in the development and regular updating of the care plan.

Recommendations for Enhancing Network Adequacy and Access Standards
We firmly believe provider networks should be exceptionally clear, accurate and accessible to beneficiaries. We recommend that LDH include stronger language around the accuracy of provider directories and be clearer about the out-of-network protections afforded to enrollees. For example, we believe LDH should require MCOs to update their online directory every 15 days as well as provide an email address and telephone number for beneficiaries to notify MCOs if any information on the provider directory appears to be inaccurate. In addition, we recommend LDH provide a uniform provider directory template that includes information on: whether providers are accepting new patients; the language spoken by each provider; specialty and subspecialty providers; language assistance services that are available at the provider's facilities and information about how enrollees can obtain such services; and the physical accessibility of the provider's facilities. MCOs should also establish separate standards for substance use disorders providers and list them separately in network directories. Mixing them

in with mental health providers in a category labeled behavioral health is confusing for consumers and may hide the existence of provider shortages. Additionally, MCOs should make available printed provider directories that are regularly updated and ready to be sent to beneficiaries if requested. In ensuring and monitoring network adequacy, we encourage LDH to be especially mindful of patients' access to essential community providers, particularly in rural and underserved areas. When responding to the RFP, MCOs should be required to explain their strategy for contracting and collaborating with essential community providers. When monitoring, LDH should take a geographic approach, looking at MCOs in health provider shortage areas and ensuring they contract with the community providers in those areas.

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

To better invest in primary care and ensure timely access to care, we recommend MCOs be required to conduct an introductory health visit with all new enrollees either in person or over the phone. During this time, MCOs can conduct a basic health assessment, help enrollees select a primary care provider (PCP) and schedule their first appointment, assist them with changing their PCP if needed and explain their health insurance benefits. To better promote and encourage the use of telehealth, LDH should develop adequate reimbursement for telehealth services to encourage the adoption and use of the technology, decrease wait times and increase availability for specialty care. Telehealth has the potential to fill some of the specialty care gaps. Strategies to encourage or require MCOs to use telehealth to improve enrollee access to care include: 1) creating a consortium of all of the payers who could work together to develop implementation plans for telehealth usage; 2) developing a training strategy for all participating health centers; 3) putting out a framework for adoption such as a toolkit for purchasing/ implementing the technology required; 4) contracting with local hospitals/ specialty care sites, etc., and 5) incentivizing providers to uptake telehealth by offering extra "quality points," subsidize costs of investments in technology, etc.

Recommendation to Improve Integration of Physical and Behavioral Health Services

We strongly believe MCOs should integrate services for substance use disorders, mental illness, other medical conditions and long-term services and supports into care delivery. We believe these services should be fully integrated into managed care delivery rather than carved out as separate plans or specialty services. MCOs should demonstrate a commitment to integration at an organizational level, such as by including both physical and behavioral health staff in leadership and organizational planning, utilizing a single, integrated data platform for physical and behavioral health data and instituting a "one-call resolution" policy, where members dial a single number for questions regarding physical and behavioral health.

In order to monitor the progress and impact of behavioral health integration efforts and incentivize plans to prioritize integration, LDH should work to align quality measurement efforts across physical, behavioral, and social health outcomes. For example, preventive services are often underutilized by people with severe mental illness, so it is important to include measures that look at rates of preventive screenings among people with serious mental illness.

An additional strategy to support further integration of physical and behavioral health is to encourage the use non-traditional providers that are critical to successfully integrated care models. For example, LDH should invest in policies that allow for integration of nontraditional service providers into provider practices and care delivery, such as Community Health Workers (CHWs) and peer counselors, who are increasingly critical to successful integrated care models. They should provide training opportunities for primary care providers on behavioral health screenings techniques, managing depression and other pertinent topics. They should also develop a program to educate members on the behavioral health resources available to them locally.

Recommendations to Advance Value-based Payment (VBP) and Delivery System Reform

We understand that value-based payments in Medicaid managed care can be a way to reward providers for the value they create, rather than solely volume, but feel strongly that safeguards must be embedded to ensure these arrangements do not harm consumers, particularly low-income consumers or consumers with complex health needs. Value-based payment arrangements should adequately adjust for risk, taking into account both physical health and social factors, to ensure providers are not dis-incentivized to provide care to patients with more complex health needs. These arrangements should also be paired with robust quality standards, including patient experience measures and patient reported outcome measures and an overall quality improvement strategy.

One approach to successfully incorporating these types of payments is for value-based payments to be phased in gradually, so that MCOs can better adapt to using them over time. For example, in New Mexico, the Human Services Department (HSD) (i.e. the agency charged with administering Medicaid) initially tested a variety of payment reforms through pilot projects before determining which methodologies to fully implement with MCOs. Next, HSD required its MCOs to each have a prescribed percentage of all provider payments in one of three levels of VBP payment arrangements, including incentives/withholding, shared savings/bundled services and full-risk capitated arrangements. In 2017, the MCOs were required to have 16% of provider payments in value-based arrangements across these three different levels. Going forward, HSD will continue to increase the overall percentage of provider payments covered under a VBP arrangement and expand the types of providers covered in various models while also focusing on arrangements for behavioral health, long-term care and nursing home providers.

Lastly, if LDH wants to move forward with an ACO model, we believe phasing in components of the ACO model over time so providers have time to adjust is key to ensuring the success of the model. We also recommend LDH require ACOs to include Federally Qualified Health Centers and other safety-net providers in their network to ensure the health needs of the most vulnerable populations are met. Furthermore, it is essential that patients are able to maintain their existing doctor and receive care at their medical home during an ACO transition, and therefore we recommend LDH develop robust care transition policies before fully moving to an ACO model. Lastly, we believe ACOs should notify consumers of their rights and responsibilities as an ACO member and believe the governance structure of the ACO board should include a patient representative so that the consumer voice is heard.

Recommendations to Promote Population Health

We strongly believe MCOs have the potential to improve population health by helping to address social and economic determinants of health such as food, housing and safety. To better address these factors, we recommend LDH leverage existing state data sources across departments to determine population health needs, as well as incorporate population health metrics into the list of quality outcome measures. MCOs should also be required to share their data with providers in a timely, organized format that allows for primary care providers to better coordinate care. The population health strategic plan should also require the MCOs to include CHWs that communicate with and assist the care teams at community health centers. Lastly, we recommend MCOs pay for services not otherwise reimbursable by Medicaid so long as there is not a net cost increase to the state, such as medical-legal partnerships that can help address population health issues.

Recommendations to Improve Care Management/Care Coordination

We believe care coordination is vital to managing an individual's care, especially for beneficiaries with complex health needs, and should be a core component of all MCOs. When done well, care coordination can reduce fragmentation and improve outcomes, but only if care coordination efforts are well-organized and consumer-focused. To help ensure care coordination is consumer-focused, we believe LDH should require MCOs to report quality measures focused on care coordination, including patient and caregiver experiences around care coordination, as well as define how MCOs will ensure care coordination and engage members in their home setting through methods such as home visits or telemedicine. Additionally, MCOs should require providers to develop care plans and, when appropriate, shared care plans that are jointly maintained and updated by enrollees, family caregivers (with member consent) and members of the care team.

We also believe MCOs should be required to employ, support and incorporate CHWs to coordinate care for high-cost enrollees, enrollees with multiple chronic conditions and Medicaid and Medicare dual-eligibles to improve care management and care coordination. We agree with LDH that MCOs, at a minimum, should use CHWs to provide the following care management functions: 1) conducting health risk assessments for all enrollees, 2) short-term care coordination, and 3) intensive care management. MCOs should also 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.

Recommendations to Increase Focus on Health Equity and Social Determinants of Health

Medicaid MCOs can address the social and economic determinants of health at three separate, but often overlapping levels: the clinical or encounter level, the organizational level and the broader community level. At the clinical level, MCOs can require providers to include social services in members' care plans. MCOs can also require providers to regularly assess individual patients' social and economic needs and provide appropriate referrals to social service organizations as well as navigational assistance for accessing social services. At the organizational level, LDH can use payment models that incentivize MCOs to coordinate social services, such as enhanced per-member per-month payments or including social services in

shared savings arrangements. At the community level, we believe MCOs should collaborate with community and social service organizations to regularly assess community needs, as well as the overall effectiveness of that collaboration. Organizations could include those that provide community-based mental health services; mental health and substance use disorder services; Medicaid funded long-term services and supports; housing crisis management services; transportation services; and food assistance services.

As discussed in previous sections, we recommend CHWs be incorporated into care delivery models to improve care management and care coordination at both the MCO and provider level as they have been proven to add tremendous value towards improving health equity and addressing the social determinants of health. CHWs play an essential role in providing assistance with navigating our complex health care system and empowering patients with the knowledge and decision-making skills they need to feel engaged in their health and health care. As pre-established leaders of their community, they're able to provide the crucial link for enrollees between the healthcare system and social and supportive services such as housing, food access, transportation, child care, translation services and employment assistance. Additionally, their ability to provide information and guidance in a culturally competent manner is critical to improving health outcomes.

To better achieve health equity overall, we recommend LDH institute training and reporting requirements as well as adjust provider payments in ways that will better help account for racial and ethnic health disparities and uncover ways to address and eliminate them. For example, LDH should require all MCO providers to undergo culturally competent care training, including for CHWS and essential community providers. Additionally, LDH should require MCOs to report clinical performance data stratified by race, ethnicity, and socioeconomic status. LDH could also risk-adjust value-based payments or otherwise incorporate equity accountability measures into payments for providers serving areas known to experience greater health disparities. LDH could further establish demonstration projects to compare effective interventions to reduce certain disparities, such as maternal health and birth disparities among racial and ethnic minorities along with projects to test payment and delivery system reform interventions to reduce disparities. Lastly, LDH could support public-private partnerships that share information with and provide referrals to social service providers and safety net programs