From: Healthy Louisiana
Sent: Wednesday, April 18, 2018 2:54 PM
To: Erin Campbell
Subject: FW: LSU Health Family Practice input into Louisiana Medicaid MCO RFP White Paper 4/2018

From: Werner, Sharon [mailto:SWerne@lsuhsc.edu]
Sent: Tuesday, April 17, 2018 6:01 PM
To: Healthy Louisiana <Healthy@la.gov>
Cc: Assercq, Jule <JGrieb@lsuhsc.edu>; Werner, Sharon <SWerne@lsuhsc.edu>
Subject: LSU Health Family Practice input into Louisiana Medicaid MCO RFP White Paper 4/2018

The following are some response comments to the Louisiana Medicaid White Paper that Drs. Jule Assercq and Sharon Werner have discussed to provide feedback from LSU Health Family Practice at the Mid City Clinic in Baton Rouge:

We feel that fewer statewide MCO's would be best - 2-3 maximum.

Regarding enhancing network adequacy and access standards, there is a serious problem with specialist access in Baton Rouge, especially neurology, neurosurgery, hematology and timely services in gynecology and orthopedics. There is also a serious lack of timely physical therapy services. We feel that the MCO's should be required to provide local access to all specialties. Having patients go to New Orleans to be seen is not working well for these specialties due to very prolonged wait times for appointments and the logistics of getting there. We feel that communication of available resources is key - if there are fewer MCO's then there would be fewer websites to go to for information and this would help. Currently with 5 MCO's we find it impractical to go to all the different sites to get information. A listing of MCO specialists, updated monthly, on a reduced number of websites would help providers in referrals and could be monitored for adequacy of specialist service availablilty. Telemedicine has some potential benefit, more for specialty consults or for some chronic disease management follow up of diabetics as an example, but we do not see how this is likely to be cost effective or logistically feasible.

Regarding utilization of telehealth/e-visits to enhance access to care, generally in our experience, the majority of our patients are not very tech savvy. We do not have lot of participation with Mychart for example. This is subject to change as our whole society becomes more tech oriented.
We feel that triage lines are useful and that MCO's should support the utilization of those already in existence in practices and help providers without them to establish them. But avoid duplication of services in this regard.

Regarding improved integration of physical and behavioral health services, we feel this is very important. We currently have a model in our practice that utilizes a social worker trained in counseling working with the primary care providers and a psychiatrist in a collaborative care relationship. The social worker is on site and available for urgent consultation to assess the patient's appropriateness for treatment through the clinic or

need for external referral for more intensive psychiatric management. The psychiatrist does not actually see patients but works with the social worker and primary care provider, advising treatment regimens. We are a larger entity which helps make this arrangement feasible but smaller provider groups or individual providers could be organized into small groups that could set up a similar program.

Regarding promoting population health, these ideas while nice seem "pie in the sky", exceeding what can actually be done. The scope should be narrowed to address some important needs, focusing limited resources. Addressing dental health needs and developing exercise opportunities in association with community entities such as churches or in the case of Baton Rouge, the park system (BREC), would be good priorities we feel.

Regarding improving care management/care coordination, clearly communication here is key. We feel that introduction of care management to high risk enrollees should come through the primary care provider to improve receptivity of the patient to participate. The MCO can identify the individuals at increased risk and then inform the provider who can discuss the care management referral. We feel that care management paperwork should be reduced to a minimum - some care plans are too long to plow through and excess patient calls should be avoided also. Community Health workers could have a role but it needs to be meaningful and actually integrate with the provider in the patient's care. In experience with plans that use these workers, at times it seems as though they are doing a separate shadow activity and not really coordinating with the provider, often in an attempt to document guidelines being met, etc.

Regarding increasing focus on health equity and social determinants of health, we do not feel that the MCO can really be responsible for all social ills and that focusing resources on a few important needs such as transportation needs and healthy food access would make the most sense.
Transportation to visits and testing is crucial and current system does not seem to work well - lack of coordination has patients from far flung areas being transported by the same provider on long treks and patients are often late to appointments. At the same time the transportation companies threaten to leave them if they are not out by a certain time despite being late. Consideration should be made of having a centralized coordination center that could help organize riders from various sectors of town, cutting down on travel time. Also patients need some sort of access to same day transportation for urgent matters not lending themselves to a 2-3 day lead time for scheduling transportation. This would include access to a non ambulance transport from medical offices to ER for appropriate patients that just need to go from office to ER but do not require EMS services.
In Baton Rouge, consideration of linking with BREADA, the local farmer's market to provide increased access to more fruits and vegetables for patients, possibly through a voucher program would be a consideration.

Regarding incentivizing patients for participation, how a patient is made to feel at office visits and in interaction with the provider practice is one of the biggest determinants of them keeping appointments. Treating the patients with respect and involving them in their health care decisions is key. Putting more energy into these efforts would likely be more effective than small token incentives.

Regarding Value-Added benefits, if MCO's can really provide something worthwhile to patients(not providers) at no additional costs then go for it but as a practical matter improving dental care and transportation access would be more important. Focus on the basics.

Regarding achieving administrative simplification, communication is again key - More education up front of new patients to the program and how it works, simplifying procedures for PA requests, having a meaningful peer to peer process(not one in which provider calls and after waiting a prolonged time and in the middle of

conversation is told that this conversation does not actually result in an authorization but is a chance for peer to peer discussion and the PA must actually be obtained as part of a written appeal.) Make the information about policies and procedures easily accessible - not on 5 different websites. Have MCO's provide customer and provider access for inquiries and complaints - get feedback beyond just a numerical rating of satisfaction on surveys. Give the option for written feedback, positive or negative. But in addition, provide a separate LDH hotline for issues that are not being addressed at the MCO level to patient or provider satisfaction.