Healthy Blue

Advancing Medicaid Managed Care in Louisiana

Community Care Health Plan of Louisiana, Inc. dba Healthy Blue Louisiana (Healthy Blue), in collaboration with Blue Cross and Blue Shield of Louisiana, is pleased to present our comments regarding the Bureau of Health Services Financing's white paper released in March 2018 titled, *Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care*. We welcome the opportunity to suggest improvements and innovations for the Louisiana Department of Health (LDH) to consider regarding the upcoming Healthy Louisiana Request for Proposals (RFP) for Managed Care Organizations (MCOs). As requested in the white paper, we have provided the following information:

- Name of individual or organization: Community Care Health Plan of Louisiana, Inc. (dba Healthy Blue Louisiana)
- If an organization, type of organization: Insurer
- Region represented by organization: Statewide

Healthy Blue proudly serves 245,000 lives for Healthy Louisiana, and has been an incumbent since the Medicaid managed care program launched in 2012. Over 200 of our employees live throughout Louisiana, providing a local commitment and understanding of the communities we serve. Our partner, Blue Cross and Blue Shield of Louisiana, founded in 1934, offers valuable insights and strategic support as the largest payer in the state with over 2,500 employees serving 1.6 million Louisianans.

Healthy Blue considers itself uniquely positioned because of this affiliation and our ability to draw upon the national experience of our ultimate parent company, Anthem, Inc., along with its affiliate health plans collectively serving more than 6.4 million people through government-sponsored programs in 21 markets. As an existing Healthy Louisiana MCO and through our strategic alliances we continue to look forward to our collaboration with LDH and Louisiana providers to offer high quality, coordinated, and cost effective valuable care for Healthy Louisiana enrollees. We greatly appreciate the opportunity to participate in this information-gathering process and would be delighted to elaborate further upon the following recommendations.

a. Limit the Number of Statewide MCOs

Please share recommendations on the maximum number of statewide MCOs the state should contract with for Medicaid.

Promoting and preserving enrollee's voice and choice should be the most important consideration in any change to the number of MCOs.

- We recommend contracting with no less than three MCOs, allowing plans to establish and maintain sustainable membership levels and at the same time protect the State against disruption if an MCO unexpectedly exits the Medicaid market.
- The maximum enrollment for a single health plan should be no higher than 40% of the population to prevent significant inequities and avoid heightened disruption if a plan with a disproportionate share exited the market.
- The minimum enrollment threshold for a single health plan should be no lower than 25% of the eligible population if the state selects three MCOs, and no lower than 20% of the eligible population if the state selects four MCOs.

b. MCOs Operating as Innovators to Achieve the Triple Aim

Please share recommendations related to how the procurement could best advance evidence-based care and meet the Triple Aim.

Care delivery strategies should support the objectives of the Triple Aim, which are: to improve the health of the population, the experience of each individual, and affordability as measured by the total cost of care. MCOs must consider the Triple Aim when developing integrated care delivery systems that arrange interventions across all acuity levels, from wellness to prevention, coordination of care, and to disease and complex care management.

To select the MCOs dedicated to advancing the Triple Aim, we suggest the following:

- The inclusion of specific questions within the RFP that require bidders to describe existing programs or solutions they have developed to address significant health-related issues in Louisiana.
- Evaluate MCOs based on their history of success in Louisiana, including an ability to establish and meet clear deliverables that help achieve the Triple Aim. The proposed innovations should be supplemented by studies, verifiable data, and proven outcomes. As LDH evaluates and scores responses, reviewers need to differentiate between MCOs that make concrete commitments versus those that write carefully crafted statements that avoid accountability.
- Request that MCOs delineate how they are going to measure outcomes for any proposed programs that seek to reduce program complexity and administrative burden.
- Ask MCOs to demonstrate how they will use clinical guidelines and policies to: determine medical necessity, establish effective UM practices, reduce duplicative services, and support the delivery of care and services using evidence-based practices in partnership with network providers.
- Evaluate MCOs based on their demonstrated ability to include key stakeholders, particularly providers, in process improvement activities such as authorization of services and resolution of appeals.
- Determine if MCOs understand how to harness health care data and advanced analytics to create evolving payment reform models and enrollee engagement strategies.
- Require MCOs to report historical implementation timeliness for Medicaid programs in Louisiana, and to describe implementation success from other markets.

c. Enhancing Network Adequacy and Access Standards

What specific delivery and care coordination approaches might MCOs employ to meet the needs of enrollees in rural and underserved areas?

While evaluating the volume of providers is a standard strategy for ensuring network adequacy in the early stages of a managed care program, it should not be the focus of evaluation as the program matures. Rather, the focus of a mature managed care program should be on the quality, not the quantity, of providers within an MCO's network. We recommend assessing MCOs on the quality of their network by examining the approaches the MCO takes to drive quality, efficiency and adequacy, as well as results demonstrated within the network. The evaluation process should focus on network development and maintenance capabilities, including network recruitment, value-based contracting, IT system capacity to support timely claims payment, delivery system innovation, provider service and education, and provider relationships. Scoring should include references from key provider types. Rather than lists of network contracts or letters of intent, we strongly recommend that LDH consider evaluating the provider network component of the RFP based upon bidder capabilities and experience.

How might the Department improve its evaluation of the adequacy of MCOs' response to enrollee health care needs in rural and underserved areas?

LDH should require MCOs to include specific strategies, and actual experience developing and enhancing provider networks for rural, frontier, and other underserved areas in Louisiana.

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

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.

Enhancing Access to Primary Care and Emphasizing Medical Homes

We recommend including questions to the RFP that require bidders to describe existing programs or solutions they have developed to increase access to primary care in Louisiana. We also suggest including questions that require MCOs to describe how they develop necessary support for a medical home model. Responses should be evaluated based on innovation, effectiveness, and satisfaction among enrollees and providers.

Because of the arduous nature of the accreditation process, many practices question the necessity and benefit of establishing an NCQA accredited patient-centered medical home (PCMH). Rather than requiring formal NCQA PCMH accreditation, we recommend some level of reimbursement for providers that adopt medical home capabilities and best practices for ingraining care coordination into treatment planning.

Louisiana may want to consider working with MCOs to establish incentive programs that attract medical professionals to underserved regions across the state. Experienced MCOs are able to address deficiencies through established network development teams that focus on the specific geographic needs in each region to assure local delivery systems are developed. MCOs should collaborate with LDH to help create or support new programs to increase provider retention and the number of providers offering behavioral health and substance use disorder services. For example, MCOs could help LDH request federal funds to support community-based residency programs.

How might the Department encourage or require contracted MCOs use of telemedicine or telehealth, and e-visits to improve enrollee access to care?

Telemedicine and E-visits to Improve Access to Care and Coordination

Healthy Blue believes that broader adoption of telemedicine and e-visits will improve access to physical health, behavioral health, and social services and supports. To improve access, we recommend expanding the role of telemedicine and e-visits within the Healthy Louisiana program. We believe the State should develop guidelines and policies for telemedicine similar to the way behavioral health and applied behavior analysis guidelines have been modernized. Healthy Blue would be glad to collaborate with LDH and develop a framework for a telemedicine program that all Healthy Louisiana MCOs can adopt.

We support the important work of Louisiana's Task Force on Telehealth access to advise the legislature on policies and practices that expand access to telemedicine or telehealth services. With legislative reforms, an opportunity arises for broader adoption among Medicaid providers to address access and availability issues while also reducing the cost of a visit. Requirements for face-to-face meetings with providers, either initially or on an ongoing basis, can be impractical for enrollees or present a barrier to care rather than a way to improvement. We support the concept of direct provider to enrollee connections occurring in the setting of the enrollee's choice, rather than relying solely upon a traditional hub and spoke delivery model. We recommend that LDH expand covered telemedicine services and allow for increased use of telemedicine instead of face-to-face services, allow the use of affordable technologies such as iPads® to provide telemedicine services, and promote effective training for facilitators and providers.

LDH should continue exploring ways to help eligible practices get started on the journey to embracing telemedicine or telehealth technologies, such as reimbursing providers for initial technology costs and promoting effective training. Additionally, codes related to telemedicine should be on the Medicaid fee schedule, reimbursed at the same rate as traditional care. We recommend that LDH allow the use of affordable technologies such as iPads to provide telemedicine services. The RFP evaluation should emphasize an MCO's previous experience and actual capability to use telemedicine to alleviate provider shortages in Louisiana.

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?

Triage and Screening Methods for Advancing Medical Homes

Effective screening systems and triage lines should be aligned with the population health approach described in our response to section *g. Promote Population Health*, supporting providers by identifying all of an enrollee's needs and delivering the enrollee to a medical home. To improve access and coordination through triage lines and screening systems, we recommend adding these services to the Medicaid fee schedule. For the upcoming Healthy Louisiana RFP, we suggest evaluating MCOs on their

ability to develop tiered solutions with features and functions that vary based on risk level and the enrollee's unique set of circumstances. For example, custom triage tools for pregnant enrollees as compared to one for enrollees who are immobile or diagnosed with a chronic condition.

e. Improve Integration of Physical and Behavioral Health Services

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.

Specialty Plans Improve Integration of Health, Services, and Supports

Healthy Blue has long supported the transformation of the health care delivery system to an integrated care model that meets enrollees' biopsychosocial needs through the integration of physical health, behavioral health, and social services and supports. As the opioid epidemic worsens, there is growing concern about how injection drug use might fuel transmission of infectious diseases. In 2015, the number of HIV/AIDS diagnoses attributed to injection drug use increased across the country, largely associated with the opioid epidemic and subsequent HIV/AIDS outbreaks; this was the first increase in two decades.[1] The demographics of people with HIV/AIDS attributed to injection drugs are increasingly similar to those most at risk for opioid use and addiction. We have found that the best way to prevent the spread of infection, and help those living with HIV/AIDS, is by establishing a Specialty Plan, procured along with the State's overall Medicaid program.

Specialty Plan Value Proposition for Enrollees, Providers, and the Louisiana Department of Health

Benefits for people living with HIV/AIDS and Their Families	Benefits for Providers	Benefits for Louisiana Department of Health
• Improved social determinants affecting healthcare • Increased knowledge of disease process and associated symptoms/complications • Increased self-management of diseases • Increased compliance with recommended clinical practice guidelines • Decreased utilization of services for hospital and emergency care	• Increased training around effective management • Support from Healthy Blue case managers to coordinate acute, social, behavioral, and supports to improve the integration of care for enrollees • Opportunities for provider incentive programs • Reduced administrative burdens associated with managed care • Increased awareness of opportunities for providing routine HIV/AIDS care during sick visits • Improved continuity and coordination of care between PCP and specialty care providers • Increased knowledge of importance of screening for depression	• Greater budget predictability while providing better care to enrollees • Healthy Blue resources that help streamline and reduce some of the State's administrative burden • Optimal coordination of benefits and services across Medicaid, Medicare, and MCOs • Increased quality outcomes • Decreased spread or progression of disease

An ideal time to select a specialty MCO is during the overall Healthy Louisiana program reprocurement. The RFP could include optional questions for each specialty program, encouraging qualified specialty health plans to respond directly to program requirements and experience for the subject populations and services. When evaluating responses to a specialty health plan RFP for individuals living with HIV/AIDS, we recommend that LDH consider the value of working with MCOs that have:

- Experience supporting and coordinating care for these populations
- Experience with recovery and resiliency
- The ability to form a local team supported by national expertise and experience

[1]Kaiser Family Foundation. Issue Brief. March 27, 2018. HIV and the Opioid Epidemic: 5 Key Points. https://www.kff.org/hivaids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/

- Experience integrating behavioral health and physical health
- An understanding of the importance of keeping behavioral health services in-house

Although effective specialty plans should feature specialists devoted to serving their covered population, we recommend selecting a specialty plan that is a subsidiary of – or closely associated with – one of the selected MCOs for the overall Healthy Louisiana program. This allows the specialty plan to leverage all the benefits a larger health plan, including operational support, national resources, and an extensive provider network with existing community knowledge. LDH may also want to consider additional populations that could benefit from a specialty plan arrangement, such as enrollees receiving applied behavior analysis services and children or young adults in the foster care system.

Extension of Coverage to Parents of Children in Foster Care

When child maltreatment is identified, but does not necessitate the removal of the child from the home, Medicaid services are provided to ameliorate the behaviors and conditions that may have led to the maltreatment. Often this includes the provision of comprehensive health services. When efforts to prevent removal are unsuccessful or unsafe, the child may require foster care services, and parents may lose Medicaid eligibility. Foster care is a temporary living arrangement and, in most cases, the plan is to reunify the child to preserve the family unit. Therefore, LDH should allow parents to retain their Medicaid eligibility while the foster care program serves their child temporarily. This will promote the overall health of our children, families, and our communities, and potentially avert long-term costs to Medicaid resulting from gaps in coverage.

f. Advance Value-based Payment and Delivery System Reform

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.

Healthy Blue applauds LDH's commitment to improving quality through alternative payment structures. We appreciate the inclusion of incentive-based performance measures into the arrangements between the State and MCOs, aligning the Health Plans and the State under a value-based model with a defined set of goals. We also support LDH's approach to value-based payment (VBP), embracing categories 2A, 2C, 3 and 4 of the Health Care Payment and Learning Action Network (HCP-LAN) alternative payment model (APM) framework, and allowing MCOs the flexibility to develop the solutions needed for each provider. Healthy Blue supports LDH's adoption of HEDIS® and CMS Core Sets of Measures for Adults and Children in Medicaid. LDH should continue seeking consensus among stakeholders to establish a clear set of performance measures that align with the State's goals for quality improvement.

Promoting Adoption of New Payment Models

To effectively drive quality and reduce cost across Louisiana's Medicaid system, we believe the most effective VBP models must be designed to "meet providers where they are." Experienced MCOs are in the best position to build relationships at the right scale for each provider and to work collaboratively to choose a payment model, data tools, care management support, and training that works best for each provider's practice. Healthy Blue supports LDH's current approach to define expectations for health plans related to VBP for providers, establishing clear and achievable targets, and setting reasonable implementation timelines for transitioning payments to providers based on volume to payments based on quality and value. With expectations defined, we recommend that LDH continue to allow considerable flexibility for health plans to determine specific incentive models within categories aligned with LDH goals and established framework.

We recommend avoiding episode-of-care payment or other bundled payment methodologies. Episode of care models are complex and require significant administrative investments in systems and reporting capabilities along with a high degree of analysis, transparency, data sharing, and cooperation from broad sectors of providers working together.

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?

LDH and Its MCOs Must Support Varying Provider Types

In keeping with an approach that meets each provider where he or she is, we recommend LDH consider VBP models that cover a wide range of provider types – from primary care to attendant care – and practice sizes. This includes incentive programs that reward providers for connecting enrollees to the behavioral, physical, and social supports they need. MCOs can then work collaboratively with providers based on their size and capabilities, provide them meaningful and actionable information, reach them at their level of technology sophistication, and provide technical assistance and support. We suggest that LDH continue to examine ways to increase technology capabilities among providers in Louisiana, such as offering grants that encourage widespread adoption of electronic document sharing to enhance care coordination. MCOs have the capabilities and resources to support these efforts and to work with providers immediately to develop the necessary data and interfaces in a way that providers can use.

VBP Models that Work for Behavioral Health Providers

Healthy Blue believes different VBP models are necessary for behavioral health. It will be important for LDH to recognize the nuances associated with these programs. The following are specific considerations for behavioral health incentives:

- Baseline data is crucial to set appropriate benchmarks and targets for VBP. The wait time would be substantial (potentially several years to gather baseline and then measure and report findings) for carving in behavioral health.
- Behavioral health providers have small membership panels, which may create challenges in measuring and demonstrating the effectiveness of their programs.

Select MCOs with Adequate VBP Experience

LDH should construct procurement processes to make sure that health plans respond to VBP questions, and are evaluated based on previous experience and results. LDH should also evaluate each MCO's proposed approach for meeting the State's VBP transformation goals, as well as how they support providers to help achieve VBP performance objectives. Descriptions should address all applicable populations and provider capabilities, recognizing that VBP will be new for some provider types.

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.

Relationships and Respective Roles of the ACO, the MCO, and LDH

Healthy Blue recommends building the ACO program into the MCO program delivery system. MCOs, including Healthy Blue and our affiliate health plans, are leaders in implementing Medicaid programs and fostering provider collaboration. Our experience has shown the greatest innovation can stem from MCOs and providers working together to improve quality and outcomes. LDH should require ACOs to engage with MCOs that approach them, with MCOs providing oversight and monitoring network quality to determine whether cost of care is curbed while outcomes improve. An effective alternative payment model requires time, but experienced MCOs have already developed the tools and capabilities to help providers speed up the transition. LDH should continue to pursue value-based purchasing models through an MCO environment, incorporating enrollment incentives to encourage MCO-ACO collaboration, as providers develop the ability to access real time data and the analytic capacity to effectively use that data to improve individual's care.

g. Promote Population Health

What are the key aspects that should be included within a population health strategic plan?

An effective population health approach meets the health needs of each person throughout their life, serving enrollees when they need care. The goal is to prevent illness and maintain or improve health of each person through the development of primary, secondary, and tertiary public health interventions. These interventions include, but are not limited to, targeted clinical programs, and wellness and

prevention strategies that improve quality and are cost effective. Key aspects of a strategic plan for population health include:

- Analytical tools to monitor and identify opportunities for clinical program development
- Risk stratification and targeted interventions, including:
  - Health screening and assessments to identify enrollees with emerging or actual risk factors
  - A care delivery system that arranges the array of interventions, from wellness, prevention, and care coordination to disease management and complex care management

Outcome monitoring and reporting so that continuous program evaluation and development can occur

A common barrier to population health improvement initiatives for the Healthy Louisiana program is the lack of a statewide interoperable health data exchange featuring data collected from the point of care, emergency departments, and admission, discharge, and transfer (ADT) alerts. An interoperable health data exchange could enhance the identification of high-risk, high-needs patients and help ensure that services are delivered according to evidence-based medicine guidelines. We suggest exploring funding avenues to implement an interoperable health data exchange that all Medicaid MCOs and their provider networks can access for population health improvement activities. While Healthy Blue understands that there are many challenges associated with the development of such an exchange, a central registry managed by the State or through a public academic liaison would be beneficial for moving the State forward in its population health efforts.

What requirements should be placed on MCOs in terms of utilizing a population health approach to care delivery?

MCOs should be able to identify current and future hotspots where there may be inappropriate utilization of health care services and the potential for poor health outcomes. MCOs should be able to demonstrate strategies for determining and addressing the root cause of population health risks. We encourage LDH to collaborate with MCOs to develop evolving public health goals.

Healthy Blue strongly believes that LDH should continue to emphasize a fully integrated model of care that addresses all needs of each individual, simultaneously coordinating physical health, behavioral health, pharmacy benefits, and social support needs. We believe LDH should continue to partner with MCOs that possess demonstrated experience delivering an integrated population health approach.

MCOs should be prepared to develop a population health strategic plan that addresses all levels of acuity across the entire population, including services that improve social determinants of health. We recommend evaluating MCOs on their experience developing population health strategic plans for other states.

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

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?

We suggest evaluating MCOs on their ability to deliver a blended approach that utilizes both telephonic and face-to-face communication for care coordination and care management, but also incorporates including Community Health Workers and peer support options. While Healthy Blue has witnessed the value in a blended approach, we recognize the importance of having a process for providing high-touch, face-to-face engagement for high-risk enrollees, including those who have complex care needs. These enrollees can be difficult to engage through telephonic care management because they may be residing in or transitioning from an institution, access care primarily through emergency services, or they may be frequently admitted to inpatient settings. For these enrollees, telephonic care management may not be the best option.

We have found that effective care management models place no restrictions or requirements on the number of phone calls or in-person patient visits that Case Managers make. The goal, simply, is to achieve positive health outcomes, and to evaluate Case Managers by how well they attain that goal. Care management models should focus on severity of illness and complexity of needs to determine most appropriate interventions. We have found that the most effective care management models include both face-to-face and telephonic components, and are person-centered to meet each individual's needs. Because Healthy Louisiana seeks to connect enrollees to the community support systems that meet their service care needs, we respectfully emphasize the importance of flexibility in meeting enrollees' individual needs and communication preferences. Many enrollees prefer telephonic, email, video conferencing, or text messaging outreach options instead of face-to-face visits, or a combination of all.

To increase the number of providers capable of performing care management and care coordination duties, we suggest implementing a pilot program to increase adoption through education and training. We suggest collaborating with MCOs and providers to leverage components of the NCQA PCMH and other health home models, and explore best practices that involve MCOs in care coordination for complex cases. LDH may want to consider tying components of the pilot to VBP models to increase provider adoption.

One of the challenges to enrollee engagement that Healthy Blue has observed is a lack of enrollee contact and demographic information available to MCOs. To improve MCO outreach and enrollment, we recommend capturing and transferring robust enrollee contact data at eligibility determination, including addresses, phone numbers, and emails.

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

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.

LDH should build upon the Permanent Supportive Housing (PSH) program and develop collaborative work streams with the Department of Children & Family Services and the Louisiana Workforce Commission. To increase MCO focus on social determinants of health, we offer the following comments and recommendations on some of the options discussed in the Commonwealth report that could improve health equity for Healthy Louisiana enrollees.

Classify certain social services as covered benefits under the State's Medicaid plan

We have observed a number of successful programs and subsidies that show a strong medical and cost return associated with social service interventions:

- Housing reimbursement and programs that offer housing directly to those who are most vulnerable.
- Transportation for medical or other important life visits. A flexible transportation subsidy is preferable if it would allow for trips to grocery stores, childcare support, job interviews, training, etc.
- High quality childcare support to increase early diagnosis of children's health issues, improve early childhood education and create opportunities for parents to seek employment, training, and education.
- Food access initiatives for healthy food through community gardens, food delivery, and other options that can reduce Louisiana's overwhelming prevalence of healthy food deserts.
- Job training and placement services to drive down medical costs by reducing long-term health issues.

We feel that care management is the most cost effective and impactful way to support people by providing a key point of contact that can navigate and arrange social service interventions. Successful programs start with a comprehensive assessment of all needs and conditions, person-centered goal setting and care plan development, and "high touch" care management.

Use value-based payments to support provider investment in social interventions

We support the use of VBP to support provider investment and focus on improving social determinants of health through interventions. To prevent unnecessary ER utilization among members that are homeless, large health systems could be offered payments to arrange housing or even offer housing. The University of Illinois Hospital system and Chicago's Center for Housing and Health launched a pilot project using

the hospital's money to get 25 patients (deemed super utilizers because of their frequent avoidable trips to the ER) into "housing first" style housing. Along with an apartment, a case manager arranges preventive care and helps schedule doctor's appointments as an alternative to the ER. A strong return on investment is associated with this pilot as a single day in the hospital typically costs more than a month of rent.

Integrate efforts to address social issues into quality improvement activities. We recommend that one of the required performance improvement plans focus on social interventions.**Reward plans through higher rates for effective investments in social interventions.**
LDH may want to consider tying auto-assignment preference to MCOs that develop and offer social interventions that improve quality scores.

The final Medicaid rules allow states to include the cost of "in lieu of services in the medical cost capitation rate calculation, qualifying for federal financing, as a substitute service or setting covered under a state Medicaid plan. "In lieu of" authority grants LDH and MCOs the powerful ability to implement groundbreaking, evidence-based delivery alternatives to covered services, such as home visiting for high-risk mothers, infants, and young children to substitute in-office visits. Although federal financial participation would not occur for "in lieu of" services completely unrelated to covered state plan services, states have the discretion to determine if an alternative service or setting is medically appropriate and a cost-effective substitute for the covered service[2]. LDH should evaluate MCOs on their previous experience establishing innovative ways of utilizing "in lieu of" services, review current state RFPs for reasonable suggestions, and give MCOs the flexibility in determination of use and applicability of "in lieu of" services.

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

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.

LDH should evaluate MCOs on their ability to demonstrate an understanding of the decisions their enrollees make, and the importance of aligning choices with optimal health outcomes. MCOs should also have experience using outcomes and objective data to guide development of incentive programs.

k. Improve Approach to Value-added Benefits

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.

Value-added Benefits for Members

Restricting the number and type of value-added benefits that MCOs can propose to offer may hamper efforts that encourage enrollees to engage in their own healthcare in meaningful ways. When bidders are required to select from a limited menu of value-added benefits, there is no opportunity to differentiate MCOs from one another. When all MCOs offer similar value-added benefits, enrollees lose the ability to select a plan that meets their unique needs.

MCOs need the freedom and flexibility to tailor value-added benefits that meet the unique needs of their enrollees, and the ability to adjust value-added benefits if they are not improving outcomes. Value-added benefits should increase member engagement. For the RFP, we recommend requesting that MCOs demonstrate sound reasoning showing how their value-added benefits improve specific health issues affecting Healthy Louisiana enrollees.

[2] Rosenbaum, S., Twenty-First Century Medicaid: The Final Managed Care Rule, Health Affairs Blog, May 5, 2016 http://www.healthaffairs.org/do/10.1377/hblog20160505.054774/full/

I. Achieve Administrative Simplification

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.

We support LDH's desire to develop a Credentialing Verification Organization (CVO) to decrease administrative burden for providers. To further reduce providers' administrative burden, we recommend evaluating and pursuing additional efforts aimed at removing and reducing common barriers to delivering care. For example, LDH should consider the creation of a centralized authorization portal that provides one point of access for all providers to obtain pre-certification requests from all MCOs. In addition to administrative simplification for providers and the State, a centralized authorization portal also supports timely delivery and continuity of care, and ensures that authorization criteria are applied consistently across providers and MCOs. This would also afford the state with the opportunity to conduct analyses of adherence and utilization data, and to refine benefit design based on members' needs. LDH and MCOs should collaborate to determine ways to simplify the authorization process, work with providers to determine the biggest problems, and make it consistent across plans. LDH should select MCOs that have demonstrated a willingness to work with other health plans in Louisiana to streamline processes for providers.

Work Requirements and Risks of Eligible Individuals Losing Coverage

Many states are considering Medicaid work requirements, also known as community engagement, as a condition of eligibility.[3] Medicaid work requirement proposals generally require beneficiaries to verify their participation in approved weekly activities, such as employment, job search, or job training programs in order to maintain benefits. Work requirements do not affect aged, blind, disabled, pregnant women, or child Medicaid coverage categories.

If work requirement initiatives use complex documentation and administrative processes, some eligible individuals could lose coverage. As a recent Kaiser Family Foundation issue brief points out, there is a real risk of eligible people losing coverage due to their inability to navigate these processes, miscommunication, or other breakdowns in the administrative process.[4] People with disabilities may have challenges navigating the system to obtain an exemption for which they qualify and end up losing coverage. Years of eligibility and enrollment experience with both Medicaid and CHIP show that complex enrollment rules and documentation result in barriers to coverage, while enrollment simplification and streamlining helps promote coverage.

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf
[4] https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/