April 17, 2018

Louisiana Department of Health, Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70802

Re: Paving the Way for a Healthier Louisiana: Advancing Medicaid Managed Care

Franciscan Missionaries of Our Lady Health System ("FMOLHS") is pleased to submit a response to the White Paper dated March 1, 2018, focused on re-designing the Medicaid Managed Care program in Louisiana. We are committed to strengthening the health of the communities we serve, starting with Medicaid beneficiaries and uninsured individuals who need us most. We are the #1 Medicaid provider in Baton Rouge based on hospital discharges, and our service area expands to serve 47 out of 64 total parishes. Across our system, Medicaid volume comprises over 20% of total system volume. Our health systems understand the obstacles care givers encounter in taking care of the underserved, and we are therefore uniquely positioned to influence the future managed care model.

In addition to our Medicaid experience, we have a substantial track record in value based care and know what it takes to be successful. FMOLHS spearheaded and built Health Leaders Network (HLN), a clinically integrated network which manages multiple populations in value-based care arrangements. HLN launched a Next Generation ACO model through The Centers for Medicare & Medicaid Services on January 1, 2018, following two years in Track 1 Medicare Shared Savings. Next Generation is distinct from other Shared Savings models in that it offers the highest level of risk and reward. See below for the full list of HLN's value based care contracts.

Payer	Type	Effective Date	Lives
FMOLHS Health Plan	Shared Savings	January 1, 2015	17,000
BCBS Quality Blue Primary Care and Value Partnership	Shared Savings / Risk	July 1, 2015	50,000
Humana Medicare Advantage	Shared Savings / Risk	January 1, 2016	14,000
Next Generation ACO (Medicare)	Shared Savings / Risk	January 1, 2018	23,000
United ACO	Shared Savings	October 1, 2016	13,000

As an organization committed to serving the underprivileged in our communities and to improving the way we deliver care through alternative delivery models, we appreciate the opportunity to provide input on the Medicaid Managed Care redesign.

Very Truly Yours,

Richard Vath, M.D.
President, FMOLHS Clinical Network
Franciscan Missionaries of Our Lady Health System

Respondent Information

Name of individual or organization: Franciscan Missionaries of Our Lady Health System

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): 2, 4, 6, 8, 9

III. Select Policies in the MCO RFP and Model Contract

a. Limit the Number of Statewide MCOs

As providers whose payer mix is dominated by Medicaid Managed Care, we appreciate the value of limiting the number of Medicaid Managed Care Organizations ("MCOs") as it helps us streamline credentialing, utilization management, and other administrative overhead related to the program, while still ensuring choice for beneficiaries. We also value the importance of the Department of Health being able to hold MCOs accountable, and this is easier to do with fewer statewide contractors. However, we believe it is important to balance the need for administrative simplicity with the need to transform the care delivery system, which is most effectively done at the local level through providers.

We propose the Department consider a model similar to that of North Carolina. North Carolina plans to contract with three statewide Commercial Plans ("CPs") as well as regional Provider-led Entities ("PLEs"). PLEs are defined as being majority owned and governed by North Carolina health systems and/or providers that serve Medicaid and must comply with the same licensing and capital reserve regulations as Commercial Plans. Given that PLEs are paid in the same manner as CPs and are held to the same regulations, administrative complexity is reduced while still allowing sophisticated providers who comply with all requirements to participate as managed care organizations at the local level.

North Carolina is not the only state that is working to unlock Medicaid value through the intersection of financing and care delivery – Arkansas and Florida are two other states in the Southeast that have explored models that tie health care delivery to its financing. In Arkansas, the provider-led Arkansas Shared Savings Entity ("PASSE") is a new model of organized care that will address the needs of certain Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs. For many years, Florida has enabling legislation that designates one of the MCO slots in each of its 11 Medicaid managed care regions to a Provider Service Network ("PSN"), if a qualified PSN applies.

In Louisiana, we propose the Department reduce the number of statewide MCOs from five to three and offer a regional option (either one region or several contiguous regions) for providers who are able to meet all the same financial and operating requirements as the statewide MCOs. Both the statewide option and regional provider-led option would still be competitively procured (i.e., the Department could award several provider-led plans, or none) and licensed by the Louisiana Department of Insurance.

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

The Department's desire to hold MCOs accountable for achieving the Triple Aim is admirable and should be paramount in selecting high performing plans and holding them accountable throughout the contract term. It is especially important that the Department dictate how MCOs work with providers in achieving these objectives. In many cases, providers are already pursuing population health initiatives and performing administrative functions. Instead of creating new processes and programs that go *around* the provider, MCOs should be incentivized to delegate activities and programs directly to providers who have the appropriate accreditations and have proven the ability to succeed. For example, HLN has clinical programs managed by ACO case managers used in other contracts listed in the opening letter.

In addition to holding MCOs accountable for working with providers to achieve the Triple Aim, we encourage the Department to consider offering regional provider-led plans; this type of plan could be a good complement to commercial MCOs, as they are aligned with key principles of the Triple Aim. Across the country, 12 million Medicaid beneficiaries are served by provider-led Medicaid MCOs. Because they are physician led, it comes as no surprise that provider-led plans typically achieve high quality outcomes – 11 of the top 15 NCQA-rated Medicaid health plans are provider-led.

In addition to performing well on quality and outcome measures, provider-led plans have important financial benefits. Clear incentives exist for providers to deliver the right care, in the right setting, at the right time. Provider-led plans also benefit from reduced overhead burden and administrative complexity since many functions are delegated directly to the providers. For example, utilization management is less burdensome because provider-led plans are able to avoid the inevitable friction that exists between plans and providers. Furthermore, provider-led plans are not beholden to stockholders and can therefore invest any profit back into the business.

Due to provider-led plans' ability to achieve quality outcomes and the aligned incentives that help them contain costs, we recommend the Department consider adding an option for provider-led plans to participate in the Medicaid managed care program.

f. Advance Value-Based Payment and Delivery System Reform

We applaud the Department in its plan to introduce value-based payment and delivery system reform into the Medicaid managed care redesign. The Louisiana Department of Health spends over $14 Billion annually (growing at nearly 7%) on the Medicaid program in our state. Despite the magnitude of spend, Louisiana still ranks as one of the lowest in terms of health

outcomes. We believe the best way to improve cost containment and clinical outcomes across the state is to give the providers most able to influence outcomes the right economic and operating model to succeed.

In the white paper, several Value Based Payment ("VBP") models are considered, such as shared savings/risk ACOs, primary care capitation, etc. We encourage the Department to require MCOs to pursue minimum levels of VBP that increase over time – enforced through "carrots" (e.g., incentive bonuses) and/or "sticks" (e.g., reducing auto-assignment of PCPs). We also believe the Department should dictate specific criteria related to MCO contractual arrangements with ACOs. Given our experience in value-based contracting at HLN, we understand how critical the economic and operating terms are of these agreements. If the Department reduces the number of MCOs, each will have even more negotiating leverage over providers. Therefore, we recommend the Department be explicit with how the contractual relationship is structured including terms such as % shared savings/risk, benchmark methodology, delegated functions, etc.

In order to accommodate providers on their glidepath to value based care, we recommend the Department structure several "Tracks" of VBP. For example, Track 1 could be a population-based payment per member per month (PMPM) with shared savings if the ACO can reduce total cost of care below a mutually agreed benchmark. PMPM amount and shared savings percentage should be approved by the Department to ensure the model gives the right incentives and support to providers. Track 2 could be a population-based payment PMPM with shared savings / shared risk if the ACO can reduce total cost of care below a mutually agreed benchmark. We recommend the percentage at risk to increase year-over-year as the ACO builds capabilities and experience. Finally, a Track 3 capitated option should be available for primary care only or for total cost of care for the attributed population. Track 3 should only be available for advanced ACOs who have proven experience taking risk for a population.

Value-based payment models are consistent with the proposal of offering regional provider-led plans. We believe provider-led health plans will be far more successful in value based payments, given the providers themselves are involved in designing the model and are accountable for transformation. There will also be a "halo" benefit – i.e., providers that are owners of a health plan will treat all their Medicaid managed care patients in a similar way, enabling them to succeed in VBP models with other MCOs.

Conclusion

We applaud the Department in the steps you are taking to transform the Medicaid managed care program in our state and appreciate the opportunity to provide our feedback. We are committed to playing a meaningful role in the transformation and hope the Department will provide opportunities for organizations like ours, who have built infrastructure and experienced success in value based care, to offer an innovate alternative to the statewide MCO model. We see exciting opportunity in the North Carolina program, which demonstrates how three statewide MCOs can co-exist with regional, provider-led plans. We recommend the Department consider this model, which would give experienced providers the levers they need to truly improve outcomes and contain costs in Medicaid managed care.