LOUISIANA HOSPITAL ASSOCIATION

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April 16, 2018

Ms. Jen Steele
Medicaid Director
Louisiana Department of Health
PO Box 91030
Baton Rouge, LA 70821
Email: jen.steele@la.gov

Dear Ms. Steele:

On behalf of our member hospitals and health systems, the Louisiana Hospital Association (LHA) appreciates the opportunity to provide input on the state's Medicaid managed care program and the upcoming procurement.

Number of MCOs
The LHA recommends that LDH reduce the number of contracted MCOs. One of the major issues our members have encountered in the existing program is the increased operational burden and costs associated with multiple administrative processes imposed by each MCO. Reducing the number of MCOs would consequently reduce that burden. Additionally, limiting the program should help to eliminate some of the weaker program networks and provide for a more comprehensive coverage option for those enrolled in Medicaid managed care.

Program Monitoring and MCO Performance
The Medicaid MCOs are technologically-sophisticated organizations that have outpaced the Department's abilities to adequately monitor and measure their performance. **LDH must sharpen its approach to plan management from a data analysis and reporting perspective.** As the Department has heard in multiple venues from providers of all types, there are real issues within the managed care program, such as denial rates and lack of access to post-acute care that need to be addressed. However, in order to properly address these issues, the Department must be able to adequately monitor and analyze the data that is submitted by the plans to fully understand the extent and nature of the issues. **We encourage LDH to invest in the technological and human resources needed to adequately monitor MCO performance.**

Network Adequacy and Care Coordination
Demonstrable access continues to be an issue within Medicaid managed care. While the plans submit reports and the Department approves networks based on those reports, placing Medicaid enrollees in appropriate levels of care remains challenging. Post-acute care, behavioral health, and home health are just a few areas where plans show providers as in-network, but patients are not accepted when placement is attempted. To further exacerbate the issue, section 8.4.3 of the existing MCO contract has not been historically enforced. While the enforcement and attention that has been brought to that contract provision by LDH in recent months is commendable, the MCOs have yet to feel the consequences of non-compliance. The LHA also appreciates the efforts and attention that LDH has directed toward the post-acute placement problem in the context of hospital payment reform discussions, and we look forward to a resolution.

On the care coordination front, in LDH literature from the RFP to the actuarial rate letters, care coordination is promoted in the context of what the plans bring to the table in improving the process. However, far too often we hear from hospitals that the MCOs do not take an active role in coordinating care, but simply provide a list of network providers (which may/may not be current) and consequently shift the risk to the hospital to find a suitable discharge provider. **Again, we encourage the Department to take appropriate steps in the next contract to hold the MCOs accountable for performing the duties for which they are reimbursed and to swiftly/consistently sanction in instances of non-compliance.**

Primary & Specialty Care/Timely Access to Care
In 2011 and 2014, each of the MCOs responded to the RFP lauding their efforts and abilities relative to network availability/access, medical homes, successes in other states, etc. In 2018, LDH is still seeking solutions to improve access and availability to care, yet physician reimbursement rates remain low and the administrative burden of participating in the Medicaid managed care program remains high. In addition to Louisiana's numerous medically-underserved areas, many providers simply cannot afford to participate at a high level in Medicaid and access will likely continue to suffer. **Improved reimbursement and meaningful financial opportunities for physicians, demonstrable MCO network access/availability, and reduced administrative burden should be more stringently required in the next contract.**

Administrative Simplification
Reducing variation is a proven tenet of cost reduction. From the onset of Medicaid managed care, the LHA and other provider groups have advocated for administrative simplification and again, we encourage the Department to standardize processes to the greatest degree possible. Where there was once a single process, there are now five additional processes for rendering care to Medicaid patients. Also, from an LDH program monitoring perspective, multiple processes and deviations inhibit the Department's ability to adequately measure performance. Some of the ongoing issues that could be addressed through standardization include, but are not limited to:

- Clinical Guidelines/Criteria: Different plans use different clinical criteria (Milliman, Interqual, etc.) for determining medical necessity. **LDH should standardize the clinical criteria within the Medicaid program. In addition to the costs providers must bear in licensing and staff training to be fluent in multiple sets of clinical criteria, managing to these different sets is an administrative burden that could be solved by instituting a single standard.** Additionally, this would potentially reduce the number of disputes, particularly in areas such as observation and post-acute care.

- Process/Requirement Change Notification: Many health plan changes are communicated via "fax blast." **More efficient and directed electronic communications should be required for these types of notices.**

- Clinical Information Submissions: Today, hospitals are required to provide multiple clinical submissions before plan decisions on authorizations are rendered. While we anticipate some of this volume to be reduced in a DRG environment, the timing of plan decisions on the material remains important. **Deadlines for information submissions by the hospitals and deadlines for the health plans to communicate their decisions should be reciprocal.** For example, if a plan requires a provider to submit clinical information by a certain time of day, then the plan should be required to render a decision by no later than the same time the following business day.

- Pre-certification and Notification Requirements: While the volume of services that require prior authorization varies by plan, the number is significant. **MCOs should be required to identify and remove prior-authorization requirements for services with extremely high approval percentages. Additionally, reducing variation and standardizing the pre-certification/notification process across all plans would improve the overall efficiency of the program.**

- Forms: Each MCO continues to maintain individual forms for various processes. Reducing the number of variations in these forms and standardizing required forms across health plans would be a tremendous reduction in administrative burden. The standardized forms that the Department developed for the Independent Review process were a step in the right direction. **The LHA recommends that LDH require standardized forms across MCOs for as many processes as possible including, but not limited to: prior-authorizations, treatment/service requests, evaluation/assessment forms, etc.**

Payment Mechanisms/Policy
In addition to preserving existing provider payment protection mechanisms such as FFS-equivalent rate floors and GME payments remaining carved out of managed care, the LHA recommends the following items be included in the next MCO contract:

- MCOs should be required to follow established Medicaid payment policy, NCCI, etc., unless specifically negotiated and mutually agreed to in contract language;

- MCOs should be prohibited from affecting payment policy through provider manual language and/or associated updates/changes.

Reporting and Transparency
LDH should enhance program transparency, and reporting should be more robust and made available in a timely manner. Meaningful information should be provided so that not only policymakers and regulators can monitor plan performance, but providers can also use it in their business and contracting decisions. States such as Kentucky have taken positive steps to make information widely available and in useful formats, and we encourage the Department to use successful state and public reporting mechanics that are already available.

Again, the LHA appreciates the opportunity to provide input on improving the Medicaid managed care program. We look forward to working with the Department on addressing the particular points of our recommendations.

Sincerely,

Paul A. Salles
President & CEO