Louisiana Public Health Institute Response to Louisiana Medicaid White Paper April 17, 2018

About the Louisiana Public Health Institute (LPHI)

LPHI, founded in 1997, is a statewide 501(c) (3) nonprofit and public health institute that translates evidence into strategy to optimize health ecosystems. Our work focuses on uncovering complementary connections across sectors to combine the social, economic, and human capital needed to align action for health. We champion health for people, within systems, and throughout communities because we envision a world where everyone has the opportunity to be healthy. For more information, visit www.lphi.org.

A. Limit the Number of Statewide MCOs

While the overall number of MCOs adds complexity to the administration and delivery of care for providers and Medicaid recipients, these complexities are intensified by the lack of standardization across the different plans with regards to credentialing, contract structure, attribution, and resources. Regardless of the overall number of MCOs (which would be more manageable at 3), standardized administrative components across all participating plans would ensure providers are better able to plan and maximize participation and performance.

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

- *MCO innovations to reduce complexity and cost*

The most important innovation to be included in the next round of MCO contracts must be the expansion of Alternative Payment Models supporting value-based care, and ensuring that contracted MCO's have sufficient tools, staff, education, and data to support providers in optimizing their performance in an effort to improve health outcomes and slow growth in the cost of care. This includes the transition of contracts towards shared savings and, eventually, shared risk models between payers and providers. While shared savings contracts are appearing more frequently even in the current round of MCO contracts, ensuring that MCOs give providers complete access to the tools and resources necessary to be successful in these arrangements should be considered as a requirement in the upcoming RFP. Examples for consideration include: Requiring the availability of claims and enrollment data for providers, and/or networks of providers, and giving these entities improved access to this data outside of individual payer portals to operationalize at a larger population level. Furthermore, ensuring that this data is available through the various Health Information Exchanges would better enable these organizations to maximize efficiency on transitions of care for Medicaid recipients.

As it relates to the evaluation of service effectiveness, improving transparency and public availability of data for MCO performance on the identified Medicaid Quality Measures will ensure accountability for plans, and will allow the most successful MCOs to showcase their successes in improving health outcomes in Louisiana.

- *Support of Evidence-based care and the Triple Aim*

In addition to providing provider education as illustrated in initiatives such as Choosing Wisely, support of evidence based care should be financially supported and incentivized at the provider level to ensure the Medicaid provider network has sufficient resources to

meet the staffing and technological requirements of providing high quality care, many of which require significant upfront investment. As mentioned in the white paper, ensuring that organizations with integrated behavioral health and primary care, organizations who have invested in establishing a robust care management infrastructure and the analytics infrastructure to support those initiatives, must have a financial structure that supports that development. This may be achieved through the introduction of a Chronic Care Management service line similar to that seen in the Medicare CCM program, incentive payments for organizations recognized as Patient Centered Medical Homes, or an enhanced PMPM care management fee that enables organizations to support these traditionally non-billable services.

- *Roll-out of innovative strategies*

While MCOs will operate on a statewide basis, it is important to consider the differences in available infrastructure and other resources on a regional basis when considering new initiatives. Many regions of the state are already fully involved in value-based care contracts and initiatives, and these relationships and developments should be encouraged in the RFP process. Similarly, MCOs must have a strategy for how to ensure rural or underserved communities and regions will receive adequate support to be successful.

This approach might support different regions of the state at different stages of the HCP-LAN strategy and roll-out of Alternative Payment Models. This pathway would also be more likely to lead to success as the state will be more equipped to identify and share successful strategies for care transformation regionally before attempting many initiatives at scale statewide.

C. Enhance Network Adequacy and Access Standards

- *Reporting and monitoring to assess access to care*

Encourage tracking of third-next available appointment for Medicaid Providers, as used in the NCQA Patient Centered Medical Home program and by the Institute for Healthcare Improvement (**Link**). Additionally, tracking and publicizing of MCO performance on related Quality Measures, such as Well Child visits, will also serve as an indicator that Medicaid recipients are receiving the care they need.

- *Improved access to transportation resources for rural and underserved communities*

Even in urban areas, transportation is one of the most commonly reported barriers to accessing care. According to Health Outreach Partners' Rides to Wellness Community Scan Project, in any given year, 3.6 million Americans miss at a minimum one medical appointment due to a lack of transportation. Missed appointments result in poor health impact for patients and increased costs to the health care system. To increase access to primary care, LDH should improve the current non-emergency medical transportation service offered to Medicaid patients. Additionally, care management and other member coordination services offered by MCOs should include assistance with coordinating transportation services to help ease the burden on patients to navigate these barriers to care.

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

- *Using Technology to improve access and coordination of care*

Health information exchanges (HIEs) are an important technology asset that can be leveraged to meet the Department's goals of improving access and coordination of care. MCOs and providers can use such a connection to share information on utilization across organizations in a timely manner. Historically, exchange of information between MCOs and providers has been cumbersome and subject to long lag times between service delivery and data reporting. Information that is not timely is not actionable.

In order to achieve coordination of care, MCOs should be encouraged to use technology to connect and strengthen the natural networks of hospitals, specialists, and primary care providers that care for their members in a given region. Providers that share geography also share patients and must use their common assets to address their common challenges.

In order to promote the adoption and sustainability of the medical home model (including provision of care management), MCOs should incentivize providers operating in such models. Likewise, MCOs should be encouraged to link patients with unattributed primary care providers to medical homes if the patient does not select his or her own provider.

Structure contract payments and deliverables in a way that incentivizes MCOs to make meaningful progress toward improving access to care in innovative ways. Care integration strategies, such as telehealth or same day specialty visits (including behavioral health) should be incentivized, or at a minimum, de facto financial penalties should be removed. For example, many medical homes have behavioral health providers on site, but billing rules that do not allow for multiple visits in a single day (for primary care and behavioral health) are a barrier to streamlined, integrated care.

In order to foster innovation, MCOs should be given latitude to implement non-traditional care delivery models and health information technologies. Additionally, MCOs implementing innovative strategies should be allowed room for failure as they test new approaches to population health management. Lessons learned from innovation failures are valid and merit dissemination to the health care community as a means to avoid the wasteful replication of unsuccessful ideas and to improve the general knowledge base around clinical transformation.

E. Improve Integration of Physical and Behavioral Health Services

- *Improve service integration and availability of same-day services across disciplines.*

MCOs should respond to the barriers preventing further integration while advancing incentives for value-based payment models that look at behavioral and physical health services and outcomes. Where possible, incentives should be given for effectively maximizing services with multiple priorities. MCOs should outline their strategy to appropriately incentivize providers to schedule those services to occur on the same day. Additionally, plans should outline strategies around improving care coordination and continuity of care as

patients with behavioral health conditions transition from one organization to another. This might involve contracting directly with the many CBOs who already provide these services for reimbursable care coordination or social services.

MCOs should be encouraged to use technology such as health information exchanges or direct secure messaging to ensure that primary care and behavioral health providers are kept informed and streamline the care coordination process for when their patients are seen at the hospital to ensure that they are seen for appropriate follow-up care.

F. Advance Value-based Payment and Delivery System Reform

- *Provider Readiness for Value-Based Payments*

Managed care organizations in Louisiana can implement new payment methodologies that reward providers who provide higher quality and more efficient care, rather than fee for service methods that do not serve patients or payers.

At present, there are differences in resources that affect which providers and locations are ready to implement VBP. However, this should not preclude MCOs from moving forward with those that are ready to implement. Different groups of providers (be it by type or region), have an unprecedented amount of resources regarding information, and thus, an ability to better manage their patient population. By utilizing existing health information exchanges and technology, both within organizations and through networks, there is a unique opportunity and infrastructure that has already been developed. By allowing regional or other networks to directly contract with MCOs, the providers are best able to manage their patient population while utilizing economies of scale and existing resources. Additionally, innovation within certain groups or regions can be used as a benchmark for knowing which resources or innovations would be best to scale in other areas of the state or statewide.

The Greater New Orleans region has a history of robust resources and a path laid to future networks with existing partnerships across sectors within, and outside of, the health care industry. Projects including the Beacon Community Grant to establish the Greater New Orleans Health Information Exchange (GNOHIE), or the current Build Health Challenge, as well as organizations such as 504HealthNet, underscore a unique synergy between community partners with a willingness to cooperate in new payment models. With the existing provider community's adoption of electronic health records, among other investments, the data is there to support collaboration from the provider side. The challenge lies within the space between the providers and payers, and having enough trust from both parties to be able to broker adoption of, and continual management for, VBP arrangements. There is support and desire from both sides of this spectrum to have a trusted broker, or intermediary, in this situation.

- *Strategies for improving provider readiness*

In addition to asking MCOs to outline their own provider education and outreach strategies, it may be in LDH's best interest to consider an independent third-party to assist in provider education and outreach. Due to the number of providers and partners involved in a transition

to value-based payments and the network overlap of the payers, it will be necessary for LDH, all participating MCOs, participating providers, and possibly even Medicaid recipients to be receiving information in a coordinated and standard approach to assure that everyone is kept up-to-date on program goals, deadlines, format, and requirements in order to adequately invest in their own internal staff and resources in preparation of the new contract round. Having a third-party partner would assist Medicaid in determining provider readiness, identify key issues that must be addressed or considered when rolling out new engagements, and coordinate the outreach and communication of any messaging.

These partners could serve in a variety of roles, between assessing provider readiness, identifying key issues, communicating timelines and requirements with the wider provider community, learning sessions or webinars, and providing hands-on technical assistance or coaching to ensure that the community is well prepared and providers have the tools to successfully participate prior to contract roll-out.

- *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.*

The development of an ACO model for Medicaid contracts and providers will be critical to assisting providers and MCOs in meeting the Triple Aim. While the HCP-LAN document (Link) outlines the different stages of transformation from volume to value, having certain parameters and guidelines publicly available will better allow providers to prepare for all contracts in a standardized way and better understand the required infrastructure, staffing, data, and technology requirements to be successful in these new arrangements. To that end, LPHI has outlined the following components to consider for ACO development:

1) Patient Attribution

MCOs should have a clear strategy around the identification and distribution of patients that will be attributed to these value-based payment contract arrangements, as well as ensure that providers have a readily available resource and point of contact around the rules and process through which to work through any questions or disputes. Having an understanding of the affected population is a key early component in any successful value-based care strategy, and so this process must be outlined early in the process.

2) Data Access and Usability

Providers (and/or networks of providers) must have ready access to actionable data about their attributed patient population. Having that data, such as demographic information, eligibility, cost/claims, hospital utilization, and more, available from all MCOs in a timely manner, and, whenever possible, working across all MCOs to standardize data format and elements available will empower providers to put data to work faster, and to spend less time on the transformation and integration of that data into their system and organization.

As similar to the provider readiness strategy outlined above, LDH must consider a data contractor to serve as a partner. This model has been seen to be successful and

fundamental in both limited and broader capacities across many of the other states that have designed Medicaid ACO programs as outlined in the CHCS Medicaid ACO Program Design Brief (Link). LDH should work with their current partners, providers and MCO community to better determine what the role and scope of data contractor(s) might be.

3) Piloted, Regional Approach

As discussed previously, LDH and MCOs should consider a staged, iterative approach to roll-out of value-based payments statewide. Regions, organizations, and provider networks with experience in these models or with the required technical capacity already in place should be supported early in the process, and through their efforts in the program, LDH and the MCOs can identify successful strategies and lessons learned to inform the roll-out to all providers statewide. Specific considerations might include provider network size, regional HIT resources, and community partnerships that encourage cross-organization collaboration around areas such as social determinants of health or care coordination.

Furthermore, LDH should outline a deliberate, but slow, pathway into two-sided, or full-risk arrangements. These type of contractual arrangements require significant investment on both the payer and provider community, and the system required to support this on a statewide level will likely take years to develop. For these reasons, LDH might consider MCOs having only a shared savings and not shared risk contractual arrangement with providers at the outset of the upcoming RFP.

4) Clear Definitions of Roles

Lastly, LDH should work with MCOs and the provider community to establish the roles and responsibilities of each group—and ensure they are adequately funded to effectively carry out these roles. ACO models require the payer and provider community to serve in a collaborative partnership, and so having these roles clearly defined around who is responsible for necessary activities, such as data analytics, care coordination, and patient outreach should be clearly outlined. This way, the provider community and MCOs are able to develop their internal staffing and technological capabilities to serve in partnership with one another and reduce any service or administrative duplication that inflates cost without improving care delivery or health outcomes.

G. Promote Population Health

- *Proposed requirements regarding a population health approach*

LDH should require MCOs to work with the Office of Public Health and regional health care and social service partners to collaboratively develop regional population health strategic plans. This could be achieved by aligning Community Health Needs Assessments developed by hospitals with the State Health Assessment and State Health Improvement Plan. These assessments assemble data and community member input to understand health conditions and barriers, establish local or regional priorities, and develop tailored/personalized, holistic strategies to improving population health.

To facilitate this, LDH should require that MCOs articulate their ability and specific plans to coordinate and collaborate with key stakeholders at a regional level including regional public health administrators, hospitals, FQHCs and other primary and specialty care providers, HIEs, health departments, social service agencies, provider networks or associations, etc. MCOs should also be incentivized to use their unique data to contribute to regional assessments and planning for population health improvement.

Additionally, MCOs should be required to articulate their plans to leverage existing technological infrastructure, such as HIEs, the LINKS immunization registry, ED registries, and others to improve population health.

- *Key aspects to include in a population health strategic plan*

This RFP should be used as an opportunity to foster further coordination and collaboration between the Office of Public Health, the MCOs, and the healthcare providers. By encouraging MCOs to have a strategy to incorporate the public health sector more fully in their ongoing strategy, organizations will be better able to use data and partnerships to inform decision making. The Pathways to Population Health: An Invitation to Health Care Change Agents document (Link) outlines a framework grounded in evidence that threads together strategies for population health management (e.g., physical/mental health and social/spiritual wellbeing) with strategies for community well-being creation (e.g., community health and wellbeing and communities of solutions) with the purpose of improving health equity.

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

- *Strategies for improving care management services*

MCOs should be required to articulate their plans to use claims and eligibility data, and outline plans to share that data with health information exchange and provider partners to assess the need and risk of their populations and use that information to guide the delivery of care management services. Specifically, they should describe their strategies and models for stratifying their population based on need and risk, outreach and engaging members, and delivering tailored care management services, and how those responsibilities can be provided in partnership with contracted providers.

LDH should incentivize MCOs and providers, especially those providing care management services, to leverage existing health information technology infrastructure to facilitate care management activities. For example, HIEs are capable of sending near real-time event notifications to participating payers and providers to notify them when their member or patient has had a hospital encounter. Notifications are a key way to deliver timely information and trigger care management activities, especially during transitions of care when it is important to act quickly to support follow up care and prevent readmissions or other adverse events.

The use of health information exchange to connect MCOs and providers will ensure that all stakeholders are aware of patient utilization trends, including transitions of care in a timely manner. Primary care providers, specialists, and hospital systems naturally cluster into

geographic networks that serve communities in different regions of the state. Improving the connections between the stakeholders in these natural networks will enable them to more effectively identify their common assets and challenges and leverage the former in order to address the latter.

The Department's goal of improving the coordination of care management services within and between MCOs and providers will require clear definitions of each entity's roles and responsibilities and high levels of timely communication between the two entities. Clear delineation of care management roles will help the Department realize its goal of reducing duplication of services and administrative burden for providers and MCOs. Providers, MCOs and patients will benefit from having clear understanding of who is supposed to provide what services in common scenarios. Primary care providers that currently provide care management to their patients should be encouraged to continue to foster and leverage these personal relationships. MCO care management services should focus on patients who are not engaged in primary care.

Once the roles and responsibilities for care management within and between MCOs and providers is established, systems of accountability must be put in place to actively monitor the effectiveness of these arrangements and improve care management delivery as needed. Proactive systems of accountability and quality improvement will maximize engagement and effectiveness of care management systems and help to ensure positive patient and provider experience with these services.

- *The role of Community Health Workers*

Community health workers can be valuable assets to health care organizations by providing access to underserved communities and connecting community members to health care and social service resources. CHWs are most effective when their relationship to the community is authentic and long-standing. For this reason MCO-employed CHWs would have the best chance for success if they are based and deployed to the communities or region where they already have relationships with key stakeholders and gatekeepers. The main work of CHWs should be face-to-face engagement with community members.

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

- *Services focusing on the Social Determinants of Health and Health Equity*

The alignment of the population health and health care sectors in recent years has established a common call to action to advance health equity and address the social determinants of health. The Robert Wood Johnson Foundation is one of many national leaders that has supported this alignment, as demonstrated by efforts to create a common definition of Health Equity (Link). The definition states "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care".

By integrating a requirement to embed strategies that promote health equity and social determinants of health into the RFP, LDH would assure that MCOs move upstream to address the key factors that have the greatest influence on individual and community health. This would allow for innovative payment and care delivery models that could improve health outcomes and reduce the total cost of care. Possible interventions and examples include:

1) MCOs should be incentivized to invest in social services and supports. This could be done through the MLR calculation to establish that investments in social services should be considered services for beneficiaries rather than administrative costs to help MCOs meet an 85% MLR threshold. It could also be done by offering incentive payments to MCOs on top of their capitation payments for meeting specific metrics related to social determinants.

2) Services that address social determinants of health, such as housing and transportation assistance, should be built into care management services provided by MCOs as well as Medicaid providers. This is particularly important for care management services offered to the most vulnerable populations for whom basic needs such as transportation and housing can have a substantial impact on health behaviors, health care utilization and cost, and outcomes.

3) MCO health risk assessments should cover topics related to social determinants of health. They could use this information when calculating a members' risk, and also ensure that this information is made available to the attributed primary care provider for recipients before their first visit so the PCP is aware of additional outreach and services that might be required in order to get to a visit.

4) MCOs should be required to report on certain quality and outcome metrics by race/ethnicity to enable measurement and tracking of health equity goals.

5) A regional approach to population health would support increased focus on social determinants and health equity by encouraging regional and local collaboration across health and social services sectors and by supporting regionally-tailored strategies and investments in populations and services based on the unique needs and assets of each region. In the Greater New Orleans region, the GNOHIE already plays an important role in driving alignment of health and social services information and supporting collaboration across health and social sectors.

6) In many cases, providers may be better positioned than MCOs to address the social needs of Medicaid members. As such, MCOs should be encouraged to collaborate with and support providers in delivering or linking to social services and supports. Important support mechanisms include passing down financial incentives to providers, making data easily available to providers, and establishing clear regional objectives and priorities to guide providers' social interventions and investments.

7) Contracting or collaborating with community programs and organizations, such as Nurse-Family Partnership, Parents as Teachers, or Healthy Start to ensure that all recipients are getting the services they need in an effective, evidence-based manner.

J. Apply Insights from Behavioral Economics to Facilitate Enrollees' Healthy Behaviors

Incentivizing patients as a strategy for change is a promising innovation that is exciting for LDH and participating MCOs to explore in the upcoming RFP. CMMI has done some promising work in this area (Link), and, while these types of programs are still in their infancy, early results demonstrate increased utilization of preventive services and high recipient satisfaction. We recommend inclusion of a section asking RFP respondents to discuss any plans around incenting patient behavior, particularly in the areas of chronic disease and smoking cessation.

L. Achieve Administrative Simplification

- *Reduction of administrative burden for participating providers*

MCOs must further standardize administrative procedures for clinical partners to reduce the duplication of work that is incumbent on contracted organizations where there are multiple MCOs. To the amount possible, Medicaid should outline and encourage standard procedures around provider credentialing, contracting, and standards of provider engagement that all participating MCOs must adhere to. Oftentimes, provider organizations are required to learn and execute incredibly individualized and tailored workflows for many administrative procedures for these multiple payers. This leads to an increased administrative burden on provider organizations which can minimize participation, cause error, and make the care delivery system more complex for the recipients.

Furthermore, we believe that it would be very beneficial to provider organizations for LDH to outline specific requirements, standardization, and prioritization around quality measures, value-based payment roll-out, and the data that will be made to provider organizations to successfully engage in these contracts. Specifically, in addition to the data that is made available in each payer's individual payer portal, there must be a strategy to make data more available, whether through LDH centrally or by requiring MCO providers to improve availability of raw data files such as claims and eligibility. By reducing the administrative and technological barriers around accessing this data, participating provider organizations will be empowered to put this information to use faster in their efforts to deliver on improving health outcomes, recipient experience, and reducing the total cost of care.