Response to LDH Whitepaper: Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care

April 17, 2018

Executive Summary

The Louisiana State University Health Sciences Center New Orleans has teaching, research, and health care functions state-wide, through its six professional schools and eight Centers of Excellence, as well as the more than one hundred hospitals and other health science related institutions throughout the State, Region, Nation, and the World, with which they maintain affiliations.

a. Limit the Number of Statewide MCOs

Request for input: *Please share recommendations on the maximum number of statewide MCOs the state should contract with for Medicaid. The state currently contracts with five Medicaid MCOs.*

The current number of MCOs (five) creates significant administrative challenges for practicing physicians. Lack of standardization with plan policies and procedures as well as claims processing, remittance advise report, and denials codes makes it very difficult to maintain compliance. Having two or three plans would ensure competition between plans and also significantly reduce the administrative burden associated with having five plans.

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

Request for input*: Please share recommendations related to how MCOs could offer innovations to reduce program complexity, administrative burden, and unnecessary costs and to improve care and population health in partnership with providers and patients. Please share recommendations related to how the procurement could best advance evidence-based care and meet the Triple Aim.*

c. Enhance Network Adequacy and Access Standards

Request for input*: Please offer suggestions for changes in the next Medicaid managed care procurement to enable the Department and its contracted MCOs improve and ensure enrollee ready access to covered services, especially in rural and underserved areas.*

- *What types of reporting and monitoring of MCO provider networks would you recommend to better assess the adequacy and timeliness of access to care for Medicaid MCO enrollees?*
- *What specific delivery and care coordination approaches might MCOs employ to meet the needs of enrollees in rural and underserved areas?*
- *How might the Department improve its evaluation of the adequacy of MCOs' response to enrollee health care needs in rural and underserved areas?*
- *Are there deficiencies in MCO provider networks in certain regions/parishes and/or covered services that LDH should specifically address in the managed care procurem*
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LDH should employ best practices from other state in developing network adequacy and access standards. *The Medicaid Access and Network Adequacy Toolkit* produced by Mathimatica could be used in developing these guidline. It uses a framework—the "5 A's of Access" developed by Penchansky and Thomas (1981)— to highlight five key factors that influence access, and adds a sixth domain, *realized access*, a key outcome often expressed as enrollees' use of appropriate services (Figure I.1).

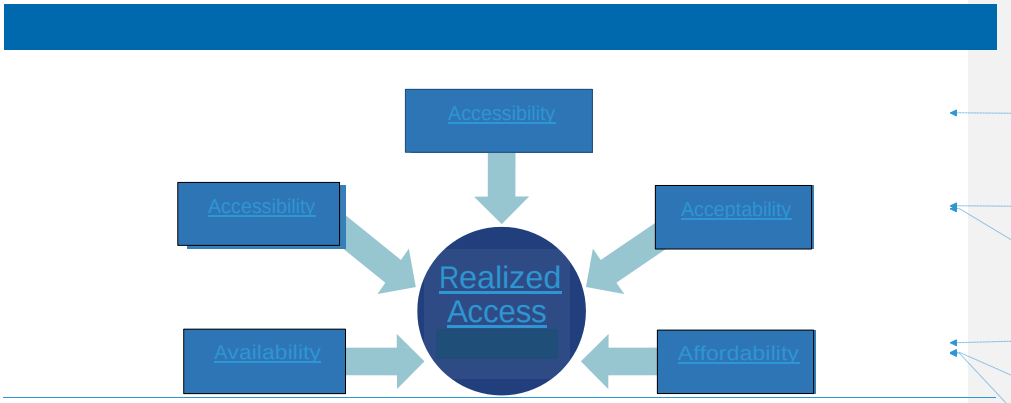

Figure I.1: Access framework

1. Availability addresses whether provider networks are sufficient to meet the needs of enrollees. Availability is a function of the number of providers, their willingness to participate in the pro-gram, and their ability to offer timely appointments. Provider participation, in turn, is influenced by reimbursement rates, timeliness of payment, and administrative burden.

2. Accessibility involves the proximity of providers to enrollees, based on geographic time and distance. For long-term services and supports (LTSS) provided in a home or community set-ting, accessibility can be expressed as the time and distance for caregivers to travel to enroll-ees' residences. At the point of care, accessibility is determined by physical access, such as ramps, and providers' ability to communicate in non-English languages or sign language.

3. Accommodation is the extent to which a provider's operating hours, appointment policies, language and cultural competencies, and approach to communications meet enrollees' con-straints and preferences.

4. Acceptability captures whether enrollees and providers are comfortable with and relate well to one another, and the extent to which managed care plans and providers respect and respond to enrollees' concerns and preferences.

5. Affordability encompasses the costs that enrollees incur relative to their ability to pay, sub-ject to Medicaid and CHIP rules limiting enrollee cost-sharing amounts.

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Setting up a process like the medical independent review panel to hear cases where wait time for an enrollee would be detrimental to their condition: Health plans need to have a department that handles access issues that providers can refer patietns to when they are unable to secure an appointment to a specialist. The plan should have to report on the number of calls, the type of provider specialty at issue and whether or not the plan had to execute a single case agreement to address the patient needs. Extra efforts would be needed to inform subscribers, and their primary care physicians, about the opportunity to seek expedited permission for out-of-network care when a plans network is inadequate to handle the patients needsresources are inadequate, and to further seek expedited external review if the insurer initially denies permission.

6. Realized access addresses managed care enrollees' actual use of the services covered under the contract. For monitoring purposes, it is most important to measure the use of clinically recommended care, such as preventive screenings and immunizations, as well as services that could be markers of potential access problems, such as hospital admissions for chronic conditions that can be avoided through regular outpatient care.

Additionally, LDH should adopt policies to ensure that provider directories are accurate. In our experience, plans do not update their systems to reflect update provided to them. This causes problems with attribution of patients to PCP's. We have experienced patients being assigned to specialists or to physicians who are no longer employed by LSU. Patient attribution problems also make it difficult to measure quality.

No-Shows: This continues to be one of the most significant challenges Medicaid providers face. In addition to not showing up for a schedule appointment, we have had several cases where patients do not show up for surgeries. LDH needs to conduct a study in conjunction with the provider and payer community to determine a root cause for this issue. Frequently incentives and/or quality metrics are focused on preventative visits. While this has been successful in increasing patients who receive preventative care, measures also need to be crafted to incentivize patients for keeping their appointments. ~~a very large problem.~~ Without adequate incentives/penalties to the plans, no shows will continue to be a problem. ~~The plans offer no support in regard to assisting with no-shows.~~ The RFP should include a provision mandating that MCO's monitor no-shows and develop action plans on how to improve patient compliance. ~~Assistance could include outreach to members who no-show to determine the cause and search for solutions.~~

~~"Phantom Care Gaps": If a patient completed a test (colon cancer screening, A1C, breast cancer screening, etc.) prior to having one of the MCO plans, once they transfer to their current MCO plan, they are still marked as "non-compliant" even if we have proof that the test was completed in the measurement period through the other insurance. They will not close the care gap UNLESS it's a claim from the current insurance. This leads to unnecessary testing and patients being marked as inaccurately non-compliant, which will ultimately harm our quality scores as well.~~

Increase Provider Quantity: The largest impediment to timely access (especially in specialties) is the limited number of physicians accepting Medicaid patients. This can be partially solved by increasing Medicaid reimbursement rates across all CPT codes.

Other General Comments: In many cases there are very few specialty services in some MCOs. They claim to have these, but if the patient calls, they are told either that that specialist was never in the

network or the specialist is not taking any more Medicaid patients. Physical Therapy simply does not exist. MCOs claim to have this, but it can be a 9 month wait. Likewise, we can get a patient in to Neurology/Neurosurgery, but they must wait as much as a year and they must go to New Orleans from Baton Rouge for access. There is no pain management.

- There must be a transparent reporting of the number of visits that the patients have to specialists. The MCOs should not be allowed to simply list specialists that in fact are not accessible.
- All complaints should go to both the MCO CEOs and to LDH.
- Annual surveys are only worth doing if they ask good questions.
- Practitioners & patients should have an input into the surveys. The surveys should always have an opportunity to make a comment about any multiple-choice question as well as a place to make general comments.

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

***Request for input**: 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.*

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

Patient Attribution (assignment of patients to PCPs)

- Often find wrong assignments of patients
- Patient contact information may not be accurate, thus creating a patient that cannot be contacted and never sees their PCP
- The above point can cause negative quality metrics
- Can a patient's Medicaid record contain their last PC visit and the provider name?

Patient Panels

- 5 plans, 5 different patient panels
- No easy way to find patient panels
- Move to a single sign logon
- Need to notify provider / group when new patients are assigned to panel
- Standardize the patient panel report

Reimbursement Reform: At the public payer level, create 1115 waiver or pilot program that allows for primary care reimbursement for currently unreimbursed care activities such as:

- Transitions of care (pre and post-discharge patient support)

- Remote chronic care management (proactive chronic care management)
- 24/7 access to primary care team

Team-Based Primary Care Delivery: Starting with urban and rural pilot programs, begin to address Medicaid patient access to primary care and associated services using an original and innovative team-based approach. Through the use of a comprehensive health care model that includes 24/7 access to a health care team, cost per patient is anticipated to decrease through lower utilization of EDs and urgent care facilities, better chronic care management, lower hospital readmissions, and identifying care gaps.

- Team-based care approach: includes physicians, nurse practitioners / physician assistants, mental health providers, pharmacy coordination, nutrition counselling, and dental professionals
- Chronic Care Management: management of patients with chronic care, utilizing combination of office visits and telephonic outreach and coordination
- Transitions of Care Focus: timely visits with patient's post-discharge to assure adherence to care plan, including medication access, coordination of specialty referrals, home care needs
- Open Access: Same day or next day appointments, 24/7 phone access to primary care team
- Wellness and Health Promotion: Targeted outreach to panels of patients for provision of wellness care, ensuring screening and prevention
- Reduced Provider Waste: Use of scribes to efficiently use provider time for care
- E-consults with Specialists: Electronic record consults for primary care providers with specialists to provide timely response for urgent specialty needs

e. Improve Integration of Physical and Behavioral Health Services

***Request for input**: 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. What specific network development, care delivery and care coordination approaches might the Department encourage or require MCOs to employ to better meet enrollees' behavioral health needs?*

Integrated Care: A much stronger linkage is needed between physical and behavioral health services. Providers, especially at the primary care level, should be incentivized to integrate behavioral health services directly into their practice. Given that behavioral health issues are often acute, having on-demand and on-site psychiatric services directly embedded into primary care facilities would provide immediate benefits in addressing comprehensive patient care. Additionally, this integration would help address the network adequacy issues and long wait times plaguing behavioral health services across Louisiana.

A major issue preventing this integration is the inability to bill for separate services received by a patient at the same facility on the same day. Changing this alone would make a remarkable difference towards improving integrated care.

At LSU Mid-City, we have developed a behavioral health program where a Social Worker with extra training in psychology sees patients who are positive on the PHQ9 questionnaire. She evaluates the patients and then consults with the LSU staff psychiatrist. The psychiatrist then sends recommendations for medication adjustment if appropriate. The Social Worker continues to see the patient to help them

with their psychological problems. A similar system might be worked out where multiple physicians have a single Social Worker similarly trained to whom they can refer patients. The social worker then could have direct access to a single psychiatrist who would be paid for the consulting services.

Studies investigating CCM among Medicare and Medicaid recipients demonstrated significant reductions in depressive symptoms, greater rates of depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life.[6,8,9] After initial investment in the first year, net cost savings per patient per year ranged from $841-$1300, corresponding to a return on investment of $6.50 per dollar spent.[14]

In response to the Louisiana Department of Health's request for feedback, we believe that the available evidence base argues in favor of requiring MCO's to adopt and implement principles of the collaborative care model in treatment of individuals with medical and behavioral health problems. Capitated Medicaid coverage with a pay-for-performance component for delivery of CCM in the upcoming managed care contracts may support improved integration of behavioral and physical health care delivery.

The information below describes the CCM mechanism itself, and payment schemes used in previous implementation efforts and programs.

A. Collaborative Care Model Infrastructure

The CCM involves a three-member team: the primary care physician (PCP), trained care management staff; such as a clinical social worker, nurse, or community health worker; and a psychiatric consultant. Patients first consult with a PCP about general health needs and for systematic screening for behavioral health conditions. If the PCP determines that a patient needs additional mental or behavioral health support, based on a previous screening test (PHQ-9) or in-person consultation, the patient is referred to care management staff. The patient's progress is closely tracked using validated tools and treatment is systematically adjusted and monitored if improvements aren't made as expected. Adjustments are determined by the primary care treatment team with input from the psychiatric consultant. Should a patient continue not to improve and/or experience an acute event, they are referred to specialty mental health care. [5-9]

To integrate this method into MCO's, we suggest the following key components of collaborative care as requirements for contract terms:

- Training and certification in delivery of Collaborative Care processes
- The appointment of or establishing, at minimum, a formal referral relationship with care management staff and a psychiatric consultant
- Mental/behavioral health screening and tracking of all patients at intake (if not done so already) and continued at each visit
- Patient-centered, CCM-based action plan outlining the method of patient care including:
    - How MH screening and progress tracking will be integrated into primary care activities
    - Care coordination and management: Communication and relationship between patient, PCP, care management staff, and psychiatric consultant

- Case review and treatment adjustment in consultation with consultant psychiatrist in the event of stagnant or worsening patient outcomes

Dr. Benjamin Springgate and the Section of Community and Population Medicine at LSU Health have more than a decade of published work and extensive experience working across the United States in close collaboration with originators and gurus of CCM such as Drs. Ken Wells and Jurgen Unutzer, providing training for physicians, care managers, psychiatrists, administrators, and entire clinical teams in the adoption and implementation of collaborative care. Dr. Springgate presently has active trainings for certifying clinical teams in Louisiana's largest metropolitan areas (Baton Rouge, New Orleans) and offers additional training opportunities across Louisiana.

B. Payment Methodologies~~Schemes~~

Payment methodologies~~schemes~~ for collaborative care is widely variable depending on implementation scale, state policy and requirements, etc. Examples of previously used payment ~~schemes~~ methodologies used in study and state-based collaborative care models include:

- Fully capitated Medicaid and Medicare coverage was used in large-scale implementations for systems like Kaiser Permanente, Veteran's Affairs and the Department of Defense.
- Case-rate payments augmenting fee-for-service billing were used in Minnesota's DIAMOND study and is similar to case-rate payment for Patient Centered Medical Home (PCMH) services.[15]
- A pay-for-performance component, used in conjunction with other billing, was used in Washington State's Mental Health Integration Program (MHIP). 25% of program payment is tied to effective treatment and performance assessment measures, including timely follow-up, demonstration of patient outcomes, systematic consultation and treatment adjustment. This method has the most substantial effect on cutting time-to-improvement.[16]

Iowa will institute a pay for performance component after the first year of its program. Performance assessment is based on state-defined quality measures. Missouri and New York will use a shared savings component to incentivize performance.[5]

BHI billing codes and coding schemes have been developed to reflect CCM activities for Medicaid reimbursement. Summaries these codes, FAQs, and billing resources are available at:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf
- https://aims.uw.edu/sites/default/files/Basic_BHI_Coding_0.pdf
- https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

Previous studies and previous implementations have used a single billing code to cover all collaborative care-based billable activities while others use a more detailed, but abbreviated coding system. [9,15]

Collaborative care enhances cost effectiveness and health outcomes for patients. Current evidence supports strongly the inclusion of a collaborative case-based plan in MCO contract requirements, third party certification-based training for providers in CCM supported by fees from MCO's, and a pay-for-performance component to Medicaid service reimbursement.

f. Advance Value-based Payment (VBP) and Delivery System Reform

***Request for Input**: 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.*

- *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?*
- *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.*

It is advised that interim steps be taken in the move towards an ACO. Initially, the Fee For Service (FFS) model could remain prevalent. Over the course of a transition period, the programs would adapt progressive payment models, similar to those seen implemented by Medicare, to encourage value-based care:

- Pay for "transition of care" codes at a higher rate, encouraging patients to get care early when discharged in an effort to reduce hospital readmissions.
- Pay for telephonic care management similar codes used by Medicare for chronic care management. Some patients can be assisted without bringing them in for office visits, opening up access to patients who need to be seen in a face-to-face setting.
- Incentivize patients and providers to do wellness exams to address preventive health, immunizations, screenings, tobacco cessation, and advance directives.
- Pay for electronic consults between specialists and primary care physicians, thus reducing wait times for specialists and freeing up their access slots for the most serious patients.
- Include a Per Member Per Month (PMPM) fee that would allow the primary care team to pay for outreach to patients in the population.

LDH may consider an ACO model that encompasses sharing a percentage of revenue dollars to support loan forgiveness for health care professionals who elect to practice primary care in areas of need or accept a faculty position in primary care. This program could be tied in with the existing LSU Health New Orleans Rural Scholars Track (https://www.medschool.lsuhsc.edu/family_medicine/rural_scholars.aspx) or federal programs associated with Health Professional Shortage Areas (HPSAs).

LSUHSC New Orleans recommends inclusion of a primary care patient risk score as part of delivery system reform. These data will help create generalizations about region populations and will allow for better estimation of financial exposure and overall population risk.

Massachusetts is currently approved on a CMS 1115 demonstration to transform their Medicaid model from pure Fee-For-Service (FFS) to accountable care, an effort they are calling MassHealth Restructuring. From reading their 1115 waiver submittal to CMS, the state is using the University of Massachusetts

Medical School's Center for Health Policy and Research to conduct data collection and evaluation. http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/1115-waiver-proposal-information.html

LSU Health New Orleans would recommend a similar approach in support of any move towards value-based payments. A joint effort between LDH and LSU Health (Schools of Medicine, Allied Health, and Public Health specifically) could bring a very powerful set of skills to addressing health care modernization in Louisiana while leveraging the robust and diverse health care workforce associated with LSU Health Sciences Center.

A concern with capitation payments is that the payment per patient would actually be commensurate with the gravity of the health issue of many Medicaid patients. Many of them are playing catch up with their medical care, receiving it for the first time in their lives. Others are struggling with the effects of poverty on their health. Capitation could be very risky financially for the practitioner. Pay for performance is likewise problematic. Many ill-informed patients simply refuse to have a colonoscopy. They refuse vaccines. We have a patient with a very high A1c who is refusing any form of injectable medicine. When they have unfounded beliefs, it is tough to get past their concerns, no matter how dedicated the physician is. There needs to be some opportunity for the practitioner to state that the patient refuses proper treatment. Or the patient is on drugs or has other mental issues that are interfering with reaching goals. In another case, we have a patient with early dementia who is uncontrollable by her family. She eats what she wants when the family or gets up in the middle of the night to eat. Her A1c is 11. Nothing the family can do except put her in a nursing home, which they will not do. A physician's PFP should not be judged badly in this situation. Physicians need an opportunity to express the specific problems.

- Currently can be based on provider or group, depending on payer
- Recommend basing on provider
- Improve metric accuracy
- "Phantom Care Gaps": If a patient completed a test (colon cancer screening, A1C, breast cancer screening, etc.) prior to having one of the MCO plans, once they transfer to their current MCO plan, they are still marked as "non-compliant" even if we have proof that the test was completed in the measurement period through the other insurance. They will not close the care gap UNLESS it's a claim from the current insurance. This leads to unnecessary testing and patients being marked as inaccurately non-compliant, which will ultimately harm our quality scores as well.

Quality Incentive Reports

- There's always a lag as to when (and if) we receive information re: our performance in the prior quarter, etc. For instance, I received a report last week for a check that was issued in January. Also, the report did not list metrics or anything helpful on a provider basis. It only contains information per location by our TIN, and all of this information is inaccurate.

g. Promote Population Health

Request for input:

- *What requirements should be placed on MCOs in terms of utilizing a population health approach to care delivery?*
- *What are the key aspects that should be included within a population health strategic plan?*

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

***Request for input**: 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? Please elaborate.*

Care Manager / Navigator: while the terminology is somewhat undefined, we recommend adding care management personnel at the provider level and allow for reimbursement, preferably at a PMPM rate. This suggestion is different in that often these personnel reside at the MCO level. We feel that moving this responsibility down to the provider level reduces complexity for the patient while strengthening the movement towards a patient centered medical home. This role would provide a variety of functions including:

- Transportation coordinator
- Appointment reminder
- Care coordination among various specialties
- Chronic condition management / data recording
- Assist with medication management
- Assist with social issues
- Provide healthy living and nutrition information
- Serve as a conduit for other social services and assistance programs

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

***Request for input**: 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.*

Scorecards/Care Gap Reports

- Most plans do not offer a scorecard of any type, and, if they do, they do not offer scorecards per provider per measure to see how each provider is performing. The scorecards are usually at a TIN level, which isn't very helpful when determining "low-hanging fruit" and areas for improvement.
- Scorecards/Care Gaps (if distributed) are not on a consistent basis – they should be received monthly to keep up with outreach, etc. instead of issuing outstanding items at the end of the calendar year and having to backtrack.
- Some plans (Healthy Blue) will only distribute care gaps in a PDF format in lieu of excel. This may seem trivial, but it's hard to work these reports. We can't make notes re: outreach, no-shows, etc. easily.

Discharge Summaries: There is usually a log with discharges. We don't receive these directly – we must go look for them on the portals. We like to get our patients in within 3-5 business days post-discharge to help lower readmit rates.

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

***Request for input**: 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.*

k. Improve Approach to Value-added Benefits

***Request for input**: 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.*

Generally, we approve of using value-added benefits to help influence enrollee behavior. However, we recommend making benefits standard across all MCOs. This will reduce complexity at the provider level and reduce confusion for enrollees.

l. Achieve Administrative Simplification

***Request for input**: 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.*

- Different payments per plan adds to confusion – needs standardization
- Credentialing
  - Current Medicaid system of credentialing per MCO is tremendously wasteful
  - Need to move towards a sole source credentialing system
- Authorizations
  - Need to standardize across all payers.
  - Create a single process regardless of payer
  - Hospital and physician authorizations- why 2 separate? Make this process easier.
- Contractual Timings
  - Need standardization for elements such as timely filing, appeals, reconsiderations, etc.
- Eligibility
  - Need standardized eligibility processes
  - Medicaid vs. plan eligibility often an issue
- Denials
  - Standardize on a denial code set with a high level of specificity
  - Need to have good remarks in denials across the board for all payers
- Refusals

- Practitioners should not be “dinged” when patients fail to get mammograms, PAPs, colonoscopies or when a patient either no shows repeatedly or simply refuse to do these.
- There needs to be a “refused” column. For some patients, these refusals are close to religious beliefs.

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