Submitted by Linda Hawkins, (no organization) Volunteer Healthcare Advocate, Abita Springs, LA 70420
Date: 4.12.18 I understand and appreciate that LDH staff may have considered most of what I am offering in this brief.

Subject: Future Vision and Policy Considerations for Public Engagement, MCOs future contracting

Policy Area: (Highlights only) Letters refer to "Paving the Way to a Healthier Louisiana" Handout at the Forum

A. Limit the number of statewide MCOs
The number of MCOs ***does not equal greater composition*** when they all are operating under the same or similar business models with slight differences, gift cards, diapers, transportation etc.
Recommendation: Perhaps different health delivery models within the contracting RFP might produce better/different outcomes.
Otherwise:
One - MCO (with enhanced requirements to subcontractor with other insurance companies) may provide simplification, standardization, consumer connections, communications and streamlined access. This business model may reduce overhead and profit margins (15% or so)/
One - Coordinated Care Organization model – Operate as an overseer (Contracting Officer Model for LDH) Oregon http://careoregon.org/LearningAndInnovation/CCO.aspx
One - Single payer model similar to the one MCO but this probably *would not be acceptable*
Video: https://vimeo.com/148933942 Fix It: Healthcare at the Tipping Point - 21 minute version
Question: If this contract is intended to be the foundation as stated for a longer term plan in changing health delivery in LA, do the expected MCO bidders have the capacity or is this Model Contract looking for bidders/contractors outside of Louisiana to come into the state?

B. MCOs currently operating have not demonstrated their capacity to innovate in and of themselves in LA regardless if they are nationally connected. They are for-profit insurance business operations and will only innovate when they see profitability. Incentives and disincentives will only come about as profit motivates them or if they perceive a threat/risk. As in A above they are all operating under the same basic insurance models and will assume they will continue unless they are monitored daily with an external entity that has the resources and power to affect their bottom line.

C. Ensure enrollees' access to covered services by broadening the workforce pool and have the ability to expand their outreach by contracting coordinating with other state departments (LA Dept. of Veterans Affairs https://www.vetaffairs.la.gov/, Educational, Labor and Transportation Departments, etc. as well as various federal agencies/operations Department of Veterans Affairs https://www.va.gov/) in shortage areas.
Incorporate clinical extenders and others, FQHC, Parish Health Units, advance nurse practitioners and others including the Workforce Commission and licensing state agents for additional information. (Example of inequities by the payment system: In Rural area, no consistency in fees (physicians paid to oversee Nurse Practitioners with little to no real supervision but receive payments.)
Require all providers in the state to accept a percentage and provide care to Medicaid patients as a part of their licensing.
Survey/poll Medicaid enrollees in multiple geographic areas for their input and recommendations. (Contact FQHCs and other nonprofit organizations for participant referrals.)
Survey/poll select providers in multiple geographic areas.
Get input, coordinate and recommendations from the Bureau of Primary Care and Rural Health http://ldh.la.gov/index.cfm/subhome/25 and have them be a part of the contract evaluation process.

D. Bidders need to actually demonstrate and address each of the areas raised with specifics rather than LDH detailing each area. Measurable accountability standards should be a part of the Model Contract with validation outside of the bidders/MCOs. Clearly define how LDH envisions their Manage Care Organizations with straight forward language inclusive of definitions so that all understand the scope of the outcomes desired.
Get input, coordinate and recommendations from the Bureau of Primary Care and Rural Health http://ldh.la.gov/index.cfm/subhome/25 and have them be a part of the contract evaluation process.
Contact providers in various geographic areas to determine what the community standards are and the expectations of the enrollees.
Reporting and monitoring of MCO provider networks at a minimum for all disciplines and services should include: wait times for initial intake appointments, wait times for follow up appointments, scheduling cancellations and delays and rescheduling. The number of provider slots and their disciplines within defined time frames, geographic availability and afterhours, 7 day-a-week options.

E. See A above and generally the following areas:
Integrate with established entities in the various geographic areas, see C above and permit bidders/contractors to subcontract.

F. LDH- Medicaid Division has become the primary outsourcer or insurer for Medicaid population coverage. In this role they now have subcontractor MCOs, etc. and the MCOs subcontract with the healthcare providers for the services. This is todays' reality.
It is important for LDH to maintain a healthy distance from the contractors to ensure effectiveness or appearance of impropriety.
Consequently direct patient/provider care is then at an arms-length and through contractors.

Payment bundling for primary diagnosis and disincentives for recurring issues when contractor failed/neglected to provide the services required.

Placed-based partnerships: What Can the U.S. and England Learn from Each Other's Health Care Reform?
http://www.commonwealthfund.org/publications/blog/2018/mar/us-and-uk-health-reform

G. The subcontractors MCOs should be able to utilize whatever clinical workers are needed if licensing, clinical and community standards are met or required.
Require bidders to actually demonstrate their capacity, ability and commitment to utilize ACOs by giving examples of their past experiences as well as the resources (funding, staff, etc.) they will dedicate to achieving the goals.

H. Various state models refer to A above. References:
Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case
http://www.commonwealthfund.org/publications/other/2018/investing-in-social-services
http://www.commonwealthfund.org/~/media/files/publications/other/2018/investingsocialservices_pdf.pdf
Placed-based partnerships: What Can the U.S. and England Learn from Each Other's Health Care Reform?
http://www.commonwealthfund.org/publications/blog/2018/mar/us-and-uk-health-reform

I. Not sure that MCOs (insurance companies) have any other motivations other than from a profit and loss standpoint.
Ref. Resource:
http://www.commonwealthfund.org/publications/blog/2018/mar/us-and-uk-health-reform
DOI/LHCC Mtg. 3.23.2018: An In-Depth Review of the Health Leaders Network's Accountable Care Organization - Quality Improvements and Cost Savings - Dr. Richard Vath, Sr. Vice President of FMOLHS; Chief Clinical Transformation Officer and President of the Health Leaders Network and Health Leaders Medicare ACO Network under FMOLHS

J. Suggest LDH poll and survey those enrolled and the providers in the Medicaid programs to let them tell you what motivates them. Also what motivates you or I may not motivate others. Personal experiences and environment and place in time all will determine the motivation at that point in time. (I typically wait until I have to see providers, do not want to waste time or be run around.)

K. The only way to achieve simplification is to limit the number of MCOs and require them to act as if they are providing universal care including all aspects of service delivery, drugs, providers, formularies and etc.
Single payer or Medicare may be the answer…see video for ideas but not sure LA would be the flagship to take this on.
Video: https://vimeo.com/148933942 Fix It: Healthcare at the Tipping Point - 21 minute version
Consult with Health Leaders Network (above) for their perspectives.
Less burdensome for providers is to reduce the number of MCOs and require them to demonstrate limited requirements including claim processing and approvals, central licensing, limited CPT and DRG coding, etc.
Report Cards on MCOs/providers published in the communities where they provide coverage. Data and report cards are to be separate and apart from the contractors who provide the services.
Patients, consumers and advocates should be a part of the entire operations in LDH and not solely the contractors' hand selected evaluators.
Go behind the data that the contractors provide LDH even though they are private in nature otherwise you only know what they give you…(garbage in garbage out issues)
Explore a MOU with the VA to access their cooperative to decrease the cost of pharmacy items
https://www.va.gov/healthbenefits/access/prescriptions.asp

Ending comments: A complete cost benefit analysis must be a part of any contracting efforts. The cost both direct and indirect should be accounted for upfront with all components, resources, staff support, opportunity cost, etc. An independent Contracting Officer or organization may help with oversight but it is imperative that MCOs be kept at arm's length to not compromise the operations.