LDH invites interested stakeholders to submit written feedback on the design elements presented in this white paper by ***April 17, 2018, 2:00 pm*** *Central Daylight Time* **via email to healthy@la.gov**.
The written submission should indicate the submitting organization and preferably be limited to no more than 10 pages. Faxed or mailed documents will not be accepted.

Woman's Hospital
Health system (women and infant specialty hospital)
Region 2

The Medicaid Managed Care procurement will be posted at the Department's web site (www.ldh.la.gov) in early 2019.

As noted below, LDH is interested in gathering feedback on specific questions related to each of these policies.

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: Aetna Better Health of Louisiana, AmeriHealth Caritas of Louisiana, Healthy Blue (formerly Amerigroup Louisiana), Louisiana Healthcare Connections, UnitedHealthcare of Louisiana.

Suggestions:
1. The number of MCOs should be limited to three which should reduce the administrative burden on providers while still allowing competition amongst the MCOs to improve outcomes.

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.

Suggestions:
1. MCOs should work with LDH and providers to establish utilization management guidelines, hospital credentialing criteria, disclosure of ownership requirements, authorization guidelines, and payment guidelines.

2. MCOs should compete by implementing programs that improve outcomes. LDH could then identify which programs had the best outcomes and establish policies consistent amongst the MCOs based on the proven efficacy of specific programs.

3. MCOs should work with providers and LDH to offer intense one on one case management for specific disease states and level of risk. This could be a shared cost outside of the separate contracts with each MCO.

4. Adhere to evidence based criteria (InterQual or MCG) in making UM decisions; consistency in practices is critically needed

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 procurement?

Suggestions:
1. LDH should work with the MCOs to ensure an adequate home health network for nursing care, DME, and home infusion is available and accessible. There are few, if any, home health pediatric services currently available
HHAs that do provide pediatric services limit the number of Medicaid patients that they accept, so there is a capacity issue for HHAs that are contracted with MCOs.

2. The cap on home health visits needs to be reviewed as this also is a reason that the few network providers that do exist either refuse to accept Medicaid patients or significantly limit the number of Medicaid patients they will see.

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?

Suggestions:
1. Periodic incentives for patients who see their primary care for their annual checkup and non emergency needs and have no true emergency ER visits may reduce ER use while increasing PCP annual visits.

2. Telemedicine and telehealth should be covered services, including psychiatric care.

3. Reimburse for screening for social determinants of health and reimburse for brief intervention provided based on screening; fund programs to assist with identified barriers

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?

Suggestions:
1. Like home health providers, psychiatric providers are not sufficiently reimbursed for their services. A review of and adjustment to the behavioral health fee schedule is needed.

2. Patients who have both medical and behavioral health needs should be assigned to a case manager to manage the care to ensure that all of the patient's needs are being addressed.

3. Do not outsource behavioral health coverage to a third party. The management of physical and behavioral health services should be provided in conjunction with each other.

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.

Suggestions:

1. Few providers will be ready for VBP arrangements by 2020. A transition is necessary from per diem to DRG to VBP arrangements. Pay for Performance, which LDH recently implemented, is a good first step in the transition to VBP.

2. If the model changes to fully capitated ACOs for all services, MCOs should be responsible for setting capitation rates for the ACOs and should contract directly with other providers not participating in an ACO.

3. MCOs and providers need to share data to determine how to best care for patients and identify the comprehensive cost for best practice care. This is not currently possible.

4. Utilization Management should be centralized with one UM entity for all Medicaid plans. The plans could share in the cost for this service. Under such a scenario, the plans would come to consensus on guidelines which LDH would approve.

5. Hospitals should not be held accountable for outcomes if hospitals are unable to implement best practice discharge plans due to restrictions in post-acute covered benefits and services, lack of network adequacy, etc.

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?

Suggestions:

1. Population Health with intense one on one case management for high risk patients is the only way to change the behavior of Medicaid members to become engaged in their care and take ownership of their health.

2. Each enrollee should be assigned a case manager depending on their level of risk.

3. Changing behavior and developing trust in the program takes years; realistic outcomes should be set.

4. Outcomes for specific disease states should be set in addition to outcomes for the overall population and each member monitored on an individual level to assess what is needed for each individual to achieve the desired outcomes.

5. Provide reimbursement to hospitals for population health programs they develop and provide to members

6. Provide reimbursement for universal screenings for social determinants performed by physicians and the resources patients need to remove barriers to care

7. BR and the surrounding area have ranked #1 in new cases for HIV/AIDS in women for several years. This trend may be reduced through education of the female population (including in the schools), improved access to care, encouraging patients to participate in PrEP/Pep programs, increasing STD education and testing, improved access to birth control options, as well as all other hierarchy needs.

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

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.

Suggestions:

1. **Use of Community Health Workers is an excellent way to connect patients within their community to needed resources.**

2. **Patient advocates would also make an impact on the patient population. Patient advocates could help build the trust needed with members and introduce them to CHWs and case managers, as well as act as a liaison between the two.**

3. **Determining the need to employ, support, or utilize CHW, and/or patient advocates would depend on the geographic area and specific disease(s) being managed.**

4. **Community health workers and patient advocates should be utilized to assist patients with removing barriers to care and provide enhanced services**

5. **Case managers should be certified**

6. **Improve the sharing of patient information and data amongst providers, payors, and LDH.**

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. For reference, see the following link to a report on "Enabling Sustainable Investments in Social Interventions: A Review of Medicaid Managed Care Rate Setting Tools," http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social- inteventions-medicaid-managed-care-rate-setting.

Suggestions:

1. Transportation; current Medicaid transportation vendors are unreliable and covered transportation benefits are limited

2. Consider contracting with ride share companies such as Uber or Lyft; there are programs in place in other parts of the country that could be used as a model.

3. Expand coverage for trips to pharmacy, visiting infant in NICU, purchase of groceries, attending support groups, etc.

4. Address social needs of members such as childcare, housing, food, violence exposure, education, health literacy.

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.

Suggestions:
1. Provide incentives based on patient engagement in healthy behaviors.

2. Design healthy rewards program; e.g. if patient attends all prenatal appointments, they will receivea car seat or safe sleep item

3. Incentives for positive actions such as members completing annual visits, follow-up, or any other positive steps should include both an initial reward and a cumulative reward to keep the member engaged in their health care.

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.

Suggestions:
1. Cover care coordination programs provided by hospitals, clinics, and other providers

2. Cover palliative care services provided by hospitals

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.

Suggestions:
1. Payer recoupment process needs to be redesigned. Recoupment needs to follow timely filing guidelines or recoupment process should have an appeal clause that allows submission of recouped claims. Please note that recoupment by one payer could result in claims submission to another payer (example: eligibility audit recoupment claim that needs to be filed to another Healthy Louisiana plan).

2. Need consistent policies and rules across payers. e.g. services requiring prior authorization, medical necessity guidelines, notification of denials process/time frame, medical necessity and payment appeals process, etc.

3. The time frame of 365 days should apply to claims filing, appeals, audits, and recoupments for all health plans.

4. All plans should utilize the same evidence based criteria for UM decisions – we recommend InterQual

5. Prohibit unnecessary prior authorizations for medications and tests for sick patients

6. All prior authorizations should be online with strict timelines included (and enforced) for verification and authorization decisions

7. Prohibit the requirement for daily clinical information for NICU, PICU, AICU patients. Reasonable and consistent guidelines amongst all plans should be established.