RFP Draft Response: Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care Future Vision and Policy Considerations for Public Engagement

Executive Summary

504HealthNet is a non-profit member association consisting of 23 organizations operating in Southeastern Louisiana, predominately in Jefferson, Orleans, Plaquemines and St. Bernard parishes. These organizations provide primary care or behavioral health services to all residents regardless of ability to pay. Collectively these independent organizations operate 70 sites and serve over 175,000 patients. Over 50% of the patients are enrolled in Medicaid.

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.

Response: The administrative complexities associated with navigating five Medicaid MCOs increases clinics' cost and creates inefficient use of staff time. We would recommend reducing the number to 3 plans to ensure competition and sufficient coverage in the event that one plan decides to withdraw from the program.

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.

Response: LDH should require the MCOs to collectively invest in solutions that are evidence-based and meet the Triple Aim. One suggestion is for them to collectively support wrap-around services for high utilizers to decrease health care system costs and improve health outcomes. For example, the Health Guardians program at UMC for frequent ER fliers has proven to decrease ER utilization, improve health outcomes and save Medicaid dollars. The MCOs should collectively support that program, decreasing costs and improving quality.

The MCO's should simplify the credentialing process across the networks using common frameworks with embedded, robust provider support and communication. The MCOs should facilitate standardization around patient data from one network to another that allows them to achieve the Triple Aim. LDH should also require the MCOs to create a framework for monitoring patient wellness and progress across not just their systems, but across the population they are serving with other partners for providers to achieve the Triple Aim.

The MCOs should also invest in remote patient monitoring as a particularly useful approach that has been proven to improve health and enhance care by increasing accountability and changing patient behaviors. Remote patient monitoring provides an opportunity for a nurse and/or community health worker (CHW) involved in care coordination to keep track of patients' health status on a daily or weekly basis, and work with patients to identify behaviors that may be impacting their health. It also allows providers to see trends or receive alerts. In a 3-year study in a Community Health Center (CHC) in North Carolina, implementing remote patient monitoring resulted in a reduction in hospital days, and hospital

visits by 83% and 79% respectively (pre vs post intervention). This study found that remote patient monitoring leads to fewer ED/ office visits, fewer hospital readmissions, improved overall health and quality of life, improved provider relationship, reduced out of pocket costs, and increased accountability. According to a report by the Wall Street Journal, annual savings from remote monitoring could amount to as much as $10.1 billion for U.S. residents with congestive heart failure; $6.1 billion for patients with diabetes; and $4.9 billion for patients with COPD. This approach is particularly needed in rural and underserved areas because it minimizes travel required for primary care and emergency visits, and barriers to accessing nurses and health screenings.

The MCOs should facilitate provider level engagement and patient level engagement tools that are across the MCOs and talk to each other. Incorporating patient feedback in a standard way (CAHPS) across the MCOs with provider level feedback will enhance patient experience.

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 approached 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?*

Response:
Transportation: Transportation continues to be an issue for patients. The Medicaid-provided transportation services are unreliable and inefficient, and they can take hours to deliver patients to their required locations.[i] LDH should strengthen the monitoring and performance requirements for the medical transportation sub-contracts to improve performance. MOCs should also consider partnering with Uber of Lyft in urban areas to provide reliable and efficient transportation to enrollees. Both services have begun partnering with insurers, health systems, and medical transport services, and have been proven to be reliable alternatives.[ii]

Patient Medicaid Look-Up: For coordination of benefits, we need a single effective system that the provider can use for multiple MCOs to track Medicaid as primary insurance coverage. Currently, patients are required to call to inquire about primary insurance coverage.

Communication: LDH should send out an updated list of providers and specialties accepting Medicaid on a monthly basis to providers. There should also be a database where clinic staff can search by zip code and provider type to determine those accepting new Medicaid patients. This would greatly aid providers in making appropriate referrals. The database should be updated on a monthly or quarterly basis.

Coordinating Placements: LDH should require the Healthy Louisiana plans to be more involved in coordinating substance abuse placement, particularly detoxification and rehabilitation. It is currently difficult for providers to find placement for their patients that need substance abuse placement. Having

Healthy Louisiana plans involved will also help with authorizations, and facilitate patients getting care more quickly. The Healthy Louisiana plans should also be more involved in coordinating inpatient psychiatric hospital admissions particularly with patients that are in the emergency department and need to be admitted to an inpatient psychiatric hospital.

Increasing Specialty Access: LDH should increase the number of specialty care providers by increasing payments or developing stronger network requirements for the Healthy Louisiana plans. LDH should require the MCOs to report out their 3rd next available appointments by specialty care clinic on a publically available website updated quarterly by region. The following specialty care providers have greater than 30-day wait times for patients in the GNO area:

- Cardiology
- Diabetes clinic
- Dentistry
- ENT
- Endocrinology
- Gastroenterology
- Neurology
- OMFS
- Ortho
- Pain management
- Podiatry
- Urology
- Women's health

In order to better care for patients, additional services, medication, and provider types need to be added to the benefit package for Medicaid enrollees. MCOs should create a pathway for recipients to access the following:

- A robust and standard dental policy. The plans should include a minimum set of dental procedures that enhance patients' physical health.
- Services provided by a licensed professional counselor (LPC)
- Outreach work/navigators embedded in clinics
- Pain management services
- Supportive therapy
- Integrative/non-opioid services from a physician
- Inpatient Electroconvulsive therapy (ECT)
- Narcan and Naloxone
- Medications for hemophilia patients
- Acupuncture
- Hepatitis C medications
- Hepatitis C treatment access by eliminating the fibrosis score, sobriety requirement, provider limitation and additional administrative barriers.

Telehealth: LDH should develop adequate reimbursement for telehealth services to encourage the adoption and use of the technology in order to decrease wait times and increase availability for specialty care. Telehealth has the potential to fill some of the specialty care gaps. Examples of telehealth programs at a community health center in rural, upstate New York include relevant programs such as dentistry, psychiatry, nutrition, neurology, HIV/AIDs care, hepatitis C care, retinopathy screening, substance use, pre-exposure prophylaxis, treatment adherence, hormone therapy), and language interpretation services.

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

<u>Request for input:</u> 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?*

Response: The Department should continue to invest in primary care, ensuring same/next day access for Medicaid patients statewide by supporting medical homes and PMPM payments to providers implementing a medical home model. They should also make it easier for patients to change their assigned PCP, and support clinics in contacting and connecting with their attributed patients. One suggestion is to require MCOs to conduct an introductory health visit with all new enrollees either in person or over the phone. During this time, they can do a basic health assessment of the new enrollee, help them schedule their first doctor's appointment of their choice, assist them with changing their PCP to their current doctor if needed, and explain to them their health insurance benefits. MCOs should consider a time based/PMPM reimbursement model to include addressing of issues related to high need patients care coordination, case management and social determinants of health.

Telehealth: The Department should require MCOs to reimburse both distant and originating site providers. Live communication, remote patient monitoring, and store and forward communications should be covered services. After increasing the scope of telehealth in Maryland, the state health department saw a $0.9 million net savings in avoided transportation costs and a $1.6 million net savings in avoided emergency department admissions.[iii] In addition, one study of 1,700 patients in upstate New York found that: 33% liked telehealth better than an in-person visit; 57% liked it just as well; 10% weren't sure; 1% found it worse.[iv] Adopting telehealth will require initial inputs such as broadband (internet), equipment, provider training and technological support. However, the cost-effectiveness of supporting telehealth interventions has been well documented.

Strategies to encourage or require MCOs to use telehealth to improve enrollee access to care include:
- Creating a consortium of all of the payers who could work on this together (ex. 504HealthNet member clinics and 3 major hospitals or specialty clinics in the area);
- Developing a training strategy for all participating health centers[v];
- Putting out a framework for adoption such as a toolkit for purchasing/ implementing the technology required, contracting with local hospitals/ specialty care sites, etc.;
- Incentivizing providers to uptake telehealth by offering extra "quality points," subsidize costs of investments in tech, etc.

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*?

Response: Supporting behavioral and physical health integration is critical to the success of the Medicaid program. Through the procurement process, LDH should work to streamline their licensing rules and create credentialing programs for providers to be able to bill for nontraditional service providers, such

as community health workers, nutritionists and peer counselors, who are increasingly critical to successful integrated care models. The state should also revise their FQHC Medicaid same-day visit policies to allow for same-day billing, and establish billing codes for emerging treatments. MCOs should also support the adoption of technology for behavioral health providers to facilitate data sharing, particularly for medication management when patients change healthcare delivery settings.

The Department should require specialized clinical expertise at the health plan level and mechanisms for achieving and maintaining provider and other stakeholders' support. Ideas include having the MCOs incentivize screenings for severe mental illness and substance use disorders (and not just depression) in a primary care setting to promote earlier detection of behavioral health issues and link patients for appropriate treatment as necessary. They should provide training opportunities for primary care providers on behavioral health screenings techniques, managing depression, substance use disorders, and other pertinent topics. They should also develop a program to educate members on the behavioral health resources available to them locally. Furthermore, the Department should bolster state capacity for robust oversight and monitoring of how plans are meeting the needs of patients with severe mental illness and substance use disorders.[vi]

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.*

Response*:*
In successful ACOs, providers need timely access to accurate, comprehensive data they can analyze to make decisions to improve health outcomes. LDH support and technical assistance for this is crucial, along with access to a robust health information exchange that allows for analytics. It is also important for LDH to provide technical expertise to providers as they make the switch to a risk-bearing ACO model. Allowing components of the ACO model to be phased in over time so providers can adjust is key to ensuring the success of the model. Developing payment methodologies that maintain adequate reimbursements to safety net primary care providers are essential.

The governance structure requirements for the board composition of the provider-led participating ACOs should include a patient representative so that the consumer voice is heard. Additionally, LDH should require 50% of the board to be comprised of experienced, practicing physicians who are currently caring for Medicaid patients. Additionally, over 50% of the representation on the board should be primary care physicians, with a requirement for behavioral health representation from a practicing psychiatrist on the board. There should also be at least one board member who can provide technical expertise on technology and population health management.

The ACOs should be provider led, and serve Medicaid as well as dual eligible enrollees. Patient

attribution should be done prospectively, and ACOs should provide care coordination, practice support, physical health services and additional services. LDH should require ACOs to include Federally Qualified Health Centers and other safety-net providers in their network. It is essential that patients are able to maintain their existing doctor and receive care at their medical home during this transition and thereafter. LDH should also pilot evidence-based strategies for patient engagement and behavior change that translate into better health outcomes. This pilot would be expanded state-wide and the lessons learned distributed.

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?*
- *Network adequacy and access; investing in primary care, timely access to care, telehealth and medical homes*

Currently primary care providers need data from the Healthy Louisiana plans about their patients in order to efficiently and effectively manage their care. MCOs should be required to share their data with providers in a timely, organized format that allows for primary care providers to better coordinate care across plans if a patient moves from one plan to another. The population health strategic plan should also require the MCOs to include community health workers that communicate with and assist the care teams at community health centers.

Another key aspect will be to ensure the MCOs are held accountable for these requirements by LDH, and that new and improved resources are appropriately and equitably distributed across enrolled populations. In the past, the MCOs have not been held to a high enough level of accountability to ensure their care coordination is designed in an effective manner or is reaching the populations who it would benefit the most. It is essential that the Department commits to ongoing monitoring and evaluation of the MCOs to confirm their adherence to the contracts. The MCOs should facilitate provider level engagement and patient level engagement tools that are across the MCO's and talk to each other.

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

<u>Request for input</u>: 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?

<u>Response</u>: MCOs should be required to employ, support, and utilize Community Health Workers (CHW) to coordinate care for high-cost enrollees, enrollees with multiple chronic conditions, and Medicaid and Medicare dual-eligibles to improve care management and care coordination. We agree that at a minimum all MCOs should use CHWs to provide the following care management functions: 1) Health Risk Assessment for all enrollees, 2) Short term care coordination, and 3) Intensive Care Management. They should also be required to invest in targeted, evidence-based use of community health workers, home visiting services, and other strategies to improve care and advance population health.

MCOs should invest in CHWs that are embedded in the community to conduct true case management and collaborate with providers, as telephonic case management is not necessarily effective. The Department should require MCOs to collectively pool a certain portion of funds to be used to hire CHWs to be employed and distributed across the state in health centers and hospitals. The Vermont Department of Heath requires payers to contribute to a pool of funds that pay for the annual salaries of CHWs that are utilized by RN-led care teams. The role of CHWs in Vermont includes helping patients: fill out insurance applications; follow treatment plans; manage stress; attend their appointments and; coordinate transportation and childcare.[vii] This model has been found to be robust and financially sustainable.

Michigan uses another model, where the MCOs are required to maintain at least one full-time CHW per 20,000 covered lives.[viii] The CHWs are integrated into the care team and are responsible for identifying community resources, coordinating and tracking referrals, supporting chronic disease self-management, providing health and wellness education, assisting with appointment-making, implementing wellness and preventative initiatives, monitoring medication adherence, and helping implement the client's clinical and non-clinical care plan goals.[ix] [x] We would recommend more than one CHW per 20,000 covered lives to increase their impact and effectiveness.

Furthermore, the contracts should ensure an adequate number of CHWs are distributed across the state, and adequately monitored and enforced. The contracts should provide clear guidance on the roles and functions of CHWs and how they will be integrated into the care team. A standardized training program for CHWs in Louisiana should be adopted for quality assurance.

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.

Response: LDH should use a multi-pronged approach to address social issues and invest in addressing social determinants of health and improving health equity. This approach should include the following options discussed in the referenced report, "Enabling Sustainable Investments in Social Interventions: A Review of Medicaid Managed Care Rate Setting Tools." The state should classify certain social services covered by Medicaid as medical assistance benefits such as: linking patients to social service programs, providing stable housing support, assisting in finding and retaining employment, and offering peer support. LDH should also pursue using incentives and withholds to encourage plan investment in social interventions, and integrate efforts to address social issues into quality improvement activities.

As discussed in the previous section, Community Health Workers (CHWs) should be required to improve care management and care coordination at both the MCO and provider level as they have been proved to add tremendous value towards improving health equity and addressing the social determinants of health. The health care system is extremely complex and CHWs play an essential role in providing assistance with navigating the system and promoting the adoption of health-seeking behaviors. CHWs are able to provide the crucial link for enrollees between the healthcare system and social and supportive services such as housing, food access, transportation, child care, translation services, and

employment assistance. Their work with enrollees in a culturally competent manner to overcome perceived and actual barriers to healthier lifestyles is critical to creating behavior change and improving health outcomes. They can also help to improve health literacy among residents in Louisiana as a way to work towards health equity. The MCO should incorporate standardized ways (assessments and ICD10) to track and facilitate issues surrounding health equity and social determinants of health.

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.

Response: It is important to meet patients where they are and implement small changes to the way choices are presented and information is framed. From our experience, in order to support healthy behaviors and choices, peer and family support is critical. Research from the Behavioral Insights team shows "tapping into informal peer-to-peer networks and allowing the people themselves to spread changes can therefore be the most effective strategy".[xi] MCOs should rely on experts in the field, and also utilize community health workers to engage and tap into behavioral economics to facilitate change. The MCOs should consider models that encourage healthy behaviors such as nutrition and exercise. They should accommodate local subscription programs such as fruits and vegetables as well exercises in an innovative manner to encourage enrollees to see the advantages of lifestyle changes. The MCOs should also consider monitoring and feedback structures to providers when such services are accessed.

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.

Response: MCOs should be allowed to offer value-added benefits and services at no additional cost in order to encourage innovation and allow patients to have access to additional benefits and services. Many of the value-added benefits are behavioral economics-based interventions aimed at incentivizing health-seeking behaviors. The MCO should replicate effective, evidence-based programs. For example, a randomized trial in South Carolina was able to increase total daily fruit and vegetable consumption by 1.6 servings by providing diabetics with $50 vouchers to a farmers' market located outside of an FQHC. New York was able to increase breast cancer screening rates by 13% and colorectal cancer screening rates by 5.6% when enrollees received a reminder to be screened in the mail and $25 after attending the screening.

LDH should support a database where providers and staff can easily determine all benefits a patient has as a covered service. LDH should also circulate the list on a regular basis to remind providers and highlight any updates or changes. Services, such as pain management, vaccines, dental and vision should be standardized, as these benefits are critical for workplace readiness and decreasing missed work days. Plans can innovate above and beyond those standard or minimum levels. We also recommend holding listening sessions or focus groups with enrollees to determine the best methods for incentivizing enrollees. The MCOs should be able to offer value-added benefits for providers.

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.

Response**:** We are supportive of the Department's efforts towards administrative complexity. Particularly the move towards a single credentialing process this summer will be helpful. It is currently a very resource intensive process that instead should be timely and coordinated across the MCO's.

Medicaid beneficiaries are frequently confused about the differences in benefits between Healthy Louisiana plans, as well as what benefits each plan covers. The Department should communicate the differences in benefits between the Healthy Louisiana plans and clearly explain what the benefits are for enrollees. In addition to sending the benefit package booklet to patients, the managed care plans should be calling their beneficiaries to let them know about their covered benefits. They should also circulate the comparison chart among providers to help educate providers about the differences.

The Department should simplify the authorization process by mandating that a common set of policies and procedures be used by all Healthy Louisiana plans. The policies and procedures should be clear, and not overly burdensome for providers to document necessity. Currently it is difficult for providers to navigate the complexity of five plans with five authorization protocols, as three plans use Interqual and two plans use Milliman care management guidelines. The same guideline should be used for the entire Medicaid population. The plans also have different policies regarding admission notification, concurrent review and observation stays.

The Department should create a single formulary for all Medicaid beneficiaries. Healthy Louisiana plans can innovate above and beyond the standard formulary if desired. It is extremely difficult for providers to navigate the five formularies and adjust their prescribing practices accordingly, impacting patient care. This results in a time consuming process for clinic staff and providers to ensure prescriptions are covered under each Healthy Louisiana plan. In addition, it can be difficult to find suitable alternatives or submit the authorization paperwork for medications that once were on the formulary, but now are no longer on the formulary. Providers should have access to a database updated in real-time to determine if a particular drug is covered. Also, the authorization process for many drugs should be made easier. The rules around approvals for medications differ, and are not clear to providers.

Providers have identified the need for a review process for medications not on the formulary but needed by patients. LDH should create an advisory board that includes community physicians to lead the formulary review process so changes and updates can be made to the formulary to improve care.

LDH should establish a smoother and more transparent process to address the accountability of Healthy Louisiana plans and provider complaints. Oversight of the Healthy Louisiana plans and actions taken by LDH are not necessarily communicated to clinicians, leading to the impression that Healthy Louisiana plans are not always held accountable by LDH for delivering what they are contractually obligated to do, affecting patient care. LDH needs to play a more active role in policy enforcement and problem resolution. The current problem resolution process is cumbersome and highly bureaucratic. For

example, first providers address problems with the plan, then involve the LA Hospital Association or another association who then contacts LDH, and then only sometimes LDH will intervene.

In order to increase communication and collaboration between LDH, the Healthy Louisiana plans and providers, LDH should develop an advisory group or "clinical ombudsman", to facilitate feedback in a collaborative manner from providers and consumers to make program improvements. This will provide feedback about how things are working on the ground. The minutes and action items should be made available to the community via a newsletter or website.

It is difficult to track and understand the various outcome measures the Healthy Louisiana plans use. Since each of the Healthy Louisiana plans is looking for different measures and outcomes, it is complicated for providers, which decreases compliance. We would like the Department to standardize the outcome measures and track them consistently across all of the Healthy Louisiana plans. We recommend the Department establish a state-level dashboard that includes certain health outcomes and metrics which will increase transparency and allow patients and providers to see progress. The California Medicaid program publishes a standardized report on a quarterly basis that allows stakeholders to track progress.

Following HIPPA requirements, LDH should establish a single database that lists the PCP, plan, and coverage for the patient in order to facilitate care. There is no real-time way for providers to search a central database to determine the plan and coverage for patients, making it difficult to appropriately care for patients. Not having this information creates problems as claims are submitted to the incorrect Healthy Louisiana plan, then must be re-submitted which delays reimbursement.

Due to the Healthy Louisiana plans assigning PCPs to beneficiaries, patients are mailed a card with a designated PCP listed on it, which may not be the PCP they have been using. We would recommend the Department make it easier for patients to change to a different PCP, through shortened phone wait times or by creating the capacity to do this easily online.

Additional transparency is needed regarding what services are covered under each plan. The Department should establish a searchable database that allows clinic staff to easily determine what services are billable. It is very difficult to determine the billable services under each plan. For example, patients will ask if a certain service, such as nutrition counseling is covered, but it is difficult for clinic staff to accurately answer the question.

All deadlines for different licenses should be centralized and streamlined to one application. For example, there shouldn't be a separate process for the mental health rehabilitation program.

LDH should create a minimum set of standard elements on claim formats that will consider claims acceptable and adequate for processing. The MCOs should not have differing requirements for claim formats. Plans should streamline claims processing to one location per plan and not have each service/benefit under the plan being processed at different locations.

The Medicaid office should have a resolution process or service level agreement for each function that the plans are expected to deliver. The Medicaid office should have a centralized mechanism for providers to report delays in processing or addressing provider needs with individual MCOs.

[i] Powers, B. W., Rinefort, S. and Sachin, J. H.. (2016). Nonemergency Medical Transportation Delivering Care in the Era of Lyft and Uber. *Journal of the American Medical Association, 316(9): 921-922.*

[ii] Chaiyachati, K. H., Hubbard, R. A., Yeager, A., Mugo, B., Lopez, S., Asch, E., Shi, C., Shea, J. A., Rosin, R. and Grande, D.. (2018). Association of Rideshare-Based Transportation Services and Missed Primary Care Appointments A Clinical Trial. *Journal of the American Medical Association Internal Medicine 178(3): 383-389.*

[iii] American Telemedicine Association. State Policy Toolkit Improving Access to Covered Services for Telemedicine. https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/2017%20-%20Feb%20ATA%20State%20Telemedicine%20Toolkit_CVG%20RMBS%20-%20Feb%202017.pdf

[iv] Mary Zelazny, CEO of Finger Lakes Community Health Center. Presentation on telehealth at the National Association of Community Health Centers conference in Washington D.C., March 16th, 2018.

[v] https://www.telehealthresourcecenter.org/toolbox-module/developing-training-strategy

[vi] Background resources: https://www.chcs.org/media/BH-Integration-Brief_041316.pdf and https://www.kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/

[vii] Bielaszka-DuVernay, Christina. (2011). Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost. *Health Affairs, 30(3).* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0169

[viii] National Academy for State Health Policy. (2017). State Community Health Worker Models. https://nashp.org/state-community-health-worker-models/

[ix] Michigan Department of Health and Human Services. (2016). Medicaid State Plan Amendment. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-15-2000.pdf

[x] National Academy for State Health Policy. (2017). State Community Health Worker Models. https://nashp.org/state-community-health-worker-models/

[xi] APPLYING BEHAVIORAL INSIGHTS SIMPLE WAYS TO IMPROVE HEALTH OUTCOMES http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2016/11/WISH-2016_Behavioral_Insights_Report.pdf