Feedback from Members of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality

Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care
http://www.Medicaid.la.gov/assets/HealthyLa/MEDICAID_MCO_RFP_WP.pdf
Due by April 17, 2018 to healthy@la.gov

1. **Limit Number of Statewide MCOs**
    a. With more MCOs there comes more sets of regulations, which in turn increases confusion and administrative burden for providers.
    b. Reducing the number of MCOs would in turn reduce the monitoring burden on Medicaid.
    c. Reducing the number of MCOs reduces overhead costs for the system; less CEOs, CMOs, HR efficiencies, etc.
    d. Medicaid should consider what the population health ramifications are from having multiple plans with members receiving different services and interventions.
    e. In keeping with CMS guidelines, Medicaid should consider limiting the number of plans to the minimum number allowable of two.
        i. A structure should be put in place to ensure that there is adequate competition between health plans on both price and member care in order to maximize taxpayer resources and improve health and patient satisfaction outcomes.
    f. If the burden of multiple plans is deemed necessary, policies should be put in place to minimize the strain on providers and ensure their satisfaction with the program.

2. **Expect MCOs to Operate as Innovators to Achieve the Triple Aim**
    a. Strides could be made towards achieving the Triple Aim if MCOs and providers had an agreed upon consistency in clinical pathways, i.e. a standard approach to common diseases and treatments.
        i. Add a baseline/floor for Medical Necessity
        ii. Utilize existing clinical resources to vet clinical guidelines
        iii. While the standard approach should be adhered to for a majority of cases, a functioning and efficient review process should be implemented which yields to the judgement of the provider in cases which deviate from the norm.
    b. Medicaid could align kick payments with desired outcomes in order to incentivize behavior from MCOs.
    c. Medicaid should reevaluate the rate structure to financially incentivize the health plans to invest in innovation and evidence based practice to work towards the Triple Aim such that the return on their investment is appealing to their shareholders.
    d. Medicaid could align quality measures with the state's population health goals and work plans. For example, collaborate with the Office of Public Health, Office of Behavioral Health, Office of Citizens with Developmental Disabilities and health initiatives led by the Office of the Governor/Children's Cabinet.
    e. In the RFP, Medicaid should require MCOs to discuss the level of evidence (emerging, promising, or best) of proposed programs and interventions they plan to offer members. There should also be discussion if these programs are developed internally or offered by a national provider organization. Pilot projects have merit, but the applicant should discuss how they plan to move the program along the continuum of evidence.

f. MCOs should be required to publicly report on strategies and interventions to improve population health during the course of the contract to allow community providers to play a role in achieving the Triple Aim and increase monitoring, evaluation and accountability.
g. Medicaid should require plans to participate in Clinical Quality Improvement (CQI) initiatives that involve stakeholders, providers, and consumers to improve care and outcomes for each quality measure.
h. Medicaid should require MCOs to contract with community providers who operate nationally recognized evidence based programs, which provide supportive services to Medicaid members known to reduce costs and improve outcomes. Programs such as Nurse-Family Partnership, Parents as Teachers, Healthy Start, and supportive pregnancy care models such as Centering Pregnancy all support the achievement of the Triple Aim and their sustainability and expansion directly benefit MCOs and their members.
i. Provider satisfaction with the MCOs and the Medicaid program is critical to program success. Provider engagement and satisfaction needs to be more clearly incorporated into the elements of the Triple Aim in Medicaid managed care.

3. Enhance Network Adequacy and Access Standards

a. Increase "secret shopping" in order to test networks for not only acceptability but also timeliness of access.
b. Other indicators that support timely access include:
    i. Wait time for appointments by provider type and diagnosis codes
    ii. Office wait time during appointments by provider type
    iii. Care coordination (looking at average number of patients shared between provider types is one kind of indicator of well-coordinated care)
    iv. Well child checks (missing timely appointments is indicative of lack of access to primary care). Although the Well-Child visit is a current clinical quality measure, it is a measure that can be used across Medicaid Sections, including both Quality and the Rate Setting and Audit team, which manages transportation.
c. Highlighting the gaps in timely access will also help inform public health needs and interventions.
d. Medicaid should provide a system (hotline, online form, email address, etc.) for members, providers, and community supports to report patient access issues. Medicaid should then have some system in place to address these concerns and close the loop with the complainant in a timely manner.
    i. Transportation services must be improved for low-income families seeking medical care. Access to a car or public transportation can often determine whether a child accesses healthcare. Furthermore, lack of transportation worsens access issues created by network inadequacy. Medicaid should define how often transportation reports will be analyzed for periodic changes and publicly share the results and corrective action plans for members. In addition to the use of CAHPS, the creation of local patient satisfaction surveys can help to address Medicaid transportation issues. Another alternative option would be to design a survey specifically created for and advertised to members. This survey would be used to report lack of transportation access or tardy appointment arrival, which can cause missed appointments. These results would highlight problem areas/trends for further investigation.

    ii. Care management and other member coordination services offered by MCOs should include much clearer assistance with coordinating transportation services to help ease the burden on patients to navigate these barriers to care.

e. Consideration needs to be made for supports for parents whose children are members but they (the parents) are not. Specifically, more support around transportation to appointments and meetings with providers would be helpful. For example, a gap may exist for parents of children who are in the NICU under current Medicaid transportation regulations as the patient is being transported; the parent's ability to travel to be with their child is critical. Addressing these issues will improve access and utilization. This could include promoting already available supports such as public transportation, MCO provided transportation, and options for family and friends reimbursement. Additionally, the department should explore opportunities for innovations such as the use of ridesharing services. Proper education needs to be provided to members around what service is appropriate when considering the urgency of the medical situation.
f. Provide for the utilization of telehealth and telemedicine to meet network needs. These strategies should be utilized and reimbursed when appropriate.
g. Medicaid should evaluate the process and remove barriers to MCOs reimbursing services outside or above the current fee schedule to increase member access to harder to obtain services.
h. The burden to find accesses to care and set appointments for members should fall back to MCOs as part of their care management obligation; it is currently on the member.
i. MCOs should engage in regular CQI projects with communities to address frequent access inadequacies engaging members, providers, and health systems to improve access and timeliness issues.
j. If the network adequacy and access standards outlined in the contract are not being met by the health plans, Medicaid should publish their corrective action plans and results on the LDH website in an effort to provide greater transparency and improve informed decision making on the part of the member and stakeholders. MCOs may be more willing to adjust provider rates, provide greater support to those who work in rural areas, accept Medicaid patients at all practice sites, and develop creative solutions to provider shortage issues when transparency and clearer penalties for non-compliance are given more weight.
k. Subspecialty providers should be separated out by adult and pediatric providers. Adult subspecialty providers cannot treat many pediatric problems. Pediatric neurologists and pediatric otolaryngologists, clinical geneticists, and developmental behavioral pediatricians are all essential subspecialists that are in short supply in Louisiana. In addition, there are not enough American Sign Language interpreters and auditory and verbal therapists.
l. An access barrier exists from the lack of interpreters available by MCOs in non-hospital outpatient settings. Clinical experience from the hospital system (which works well and should be used as a model) suggests that the use of interpreters in different forms are not equally successful and strides should be made towards the highest level of service along the continuum of 1) in person, 2) then video, then 3) telephonic. Providers and members often need translation for languages such as Spanish, Vietnamese, and Korean etc.

4. **Invest in Primary Care, Timely Access to Care, Telehealth and Medical Homes**
    a. Provide for reimbursement for both telehealth and telemedicine.
    b. Telehealth and telemedicine are critical to meet the shortfalls in access to providers for behavioral health.
    c. A common definition for a medical home is necessary in order for all parties to understand; then implement protocols and incentivize providers to put the medical homes into practice.
    d. Parameters and possibly requiring a specific evidence based model for a Patient Centered Medical Home is necessary to ensure that the program is instituted with quality and consistency across MCOs.
    e. The contract should require MCOs to pilot contracts with primary care providers to engage in the Direct Primary Care model.
    f. To improve the effectiveness of triage lines, Medicaid contract monitors should regularly audit these triage lines for clinical effectiveness, customer service, and utilization.
    g. In addition to ensuring network adequacy for primary care, Medicaid should also include a requirement to assure utilization of primary care to improve population health and work towards the Triple Aim.

5. **Improve Integration of Physical and Behavioral Health Services**
    a. Reimbursing for telemedicine and telehealth and providing technical assistance and encouraging co-location could increase integration in primary care
    b. Providing reasonable reimbursement for behavioral health screening and intervention to primary care providers will incentivize the provider to increase the length of the appointment time in order to better address behavioral health needs.
    c. Many current medical homes have behavioral health providers on site, but billing rules that do not allow for multiple visits in a single day (for primary care and behavioral health) are a barrier to streamlined, integrated care.
    d. Coordination of data systems between primary care, behavioral health, and community providers (home visiting, schools, school based health clinics etc.) would reduce the multiple administrations of the same screenings and improve care coordination.
    e. Medicaid should encourage plans to look at contracting with community providers who support client's behavioral health outside a traditional clinic setting including home visiting programs and infant mental health specialists.

6. **Advance Value-based Payment (VBP) and Delivery System Reform**
    a. VBP and Accountable Care Organizations (ACOs) need a common definition created by Louisiana Medicaid in order to spur further conversation and innovation.
    b. VBP systems are likely difficult to implement for independent providers as they do not manage enough service lines to attend to the needs of the whole patient and may not be able to spread costs across their patient population to work within thin margins. Larger health systems may have the resources necessary to achieve the cost savings associated with VBP.
    c. VBP and ACOs are likely difficult to implement and are not as feasible with the current MCO structure which adds an additional layer of management and thus reduces margins.

d. Medicaid should work with the healthcare community to identify pockets of possible readiness in order to offer TA and pilot VBP arrangements before rolling out a full ACO program.
e. As systems are developed to pay for quality and outcomes leading to VBP and ACO relationships, integration with population health initiatives and existing programs of the state should be aligned in order to maximize results and system wide effects.
f. Until proper VBP arrangements can be put in place, providers both clinical and community should be able to bill to recoup care and case management costs that they are currently providing to fill the gap left by plans. In many cases, providers are scheduling appointments, securing DME, providing case management between appointments, and advocating for clients to the MCO care and case managers. Until MCOs are able to adequately provide these services or enter into VBP arrangements, providers should be able to bill for them.

7. Promote Population Health

a. Medicaid should utilize public health professionals to develop and implement a consistent definition of population health for both Medicaid and the MCOs to follow. For example, consult the American Public Health Association and the Institute of Medicine for a definition.
    i. Regardless of who is responsible for providing case management and population health services there should be a common definition, standards, monitoring, evaluation, and CQI in place. These strategies and goals should be shared amongst plans to generate economies of scale.
b. Population health does not exist in a vacuum; MCOs should be required to discuss in their response to the RFP how they will integrate with systems of care, their fellow MCOs, and initiatives of the state outside of Medicaid. During the course of the contract, MCOs should report their efforts related to this integration, which should be available publically to encourage further collaboration.
c. The MCOs should promote and refer to population health evidence-based programs from the Office of Public Health that are designed to serve their populations, such as home visiting programs such as Nurse Family Partnership and Parents as Teachers from the Office of Public Health-Bureau of Family Health.
d. The MCOs should use health promotion materials developed by the Office of Public Health Bureau of Family Health programs to improve health and prevent mortality, such as Give Your Baby Space to promote safe infant sleeping.
e. Inconclusive evidence exists regarding the benefit and efficacy of health fairs and community screenings.

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

a. At a minimum, Medicaid needs to re-design standards of care and set minimum expectations. The current process and implementation elicits very low participation in case management with the current group of MCOs.
b. Define and structure Medicaid risk-stratified, tiered (e.g., basic, moderate, and intensive) levels of care coordination/case management. For example,
    i. Define three levels of care coordination/case management in managed care contracts.
    ii. Use children with special health care needs national screening tool to identify a group qualifying for enhanced care coordination/case management.

iii. Use algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk among children and their families.

c. MCOs should have to coordinate care with community-based providers.

d. Medicaid should require MCOs to stratify members based upon their care management needs. As members require more intense levels of care management, MCOs should be required to offer that care at the highest level of evidenced based intervention available and encouraged to contract that work to established community providers to move the care closest to the patient and the local system. The care management needs include not only clinical needs, but also social supports to address the social determinants of health and be offered in an equitable manner

e. As a part of its monitoring function, Medicaid should require MCOs to regularly and publicly report on the structure of their care and case management systems including staffing types, interventions and services offered, manager to member ratios, and utilization. MCOs should also regularly provide a summary of services and how to access them which can be shared with the public. This would make it easier for providers, other care coordination, and social support entities to coordinate with the MCOs.

f. In the RFP, MCOs should be required to describe their strategies for care/case management and identify the staff who will be executing these functions. In their response, MCOs should describe why it is the right intervention with the right provider type for the member whether it be an MD, PA, NP, RN, LPN, Community Health Worker, or paraprofessional. MCOs should report on this throughout the duration of the contract.

g. If Medicaid is to require the use of Community Health Workers, they should think about the required credentialing and look at the educational systems in the state to ensure that there exists enough CHW programs to meet the demand. Additional thought needs to be put into who will bear the cost of the credentialing; provider or MCO? Additionally, this would offer an opportunity for Medicaid to collaborate with the Louisiana Workforce Commission as well as higher education systems.

h. The medical home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a health care provider to provide comprehensive and continuous medical care to patients with the goal of obtaining maximal health outcomes. MCOs should all use the same exact criteria to define high performing pediatric medical homes, select the same performance measures, and incentivize practices and clinics to deliver quality services.

i. Characteristics of the PCMH should include:
    i. High performance on access to care measure and high percentage of children receiving well-child visits;
    ii. High rates of children who are up-to-date on recommended well child visits and immunizations (or a pediatric preventive services bundle);
    iii. Screening for general development, social-emotional development, special health care needs, maternal depression, and social determinants of health, including high performance on developmental screening measure;
    iv. Effective care coordination/case management with high rates of completed referrals;
    v. Demonstrated family engagement, measured by satisfaction with care and use of Bright Futures pre-visit tools or Well-Visit Planner;

vi. High performance on measure for weight assessment and counseling;
vii. Low rates of unnecessary emergency department utilization; and
viii. Additional resources provided in practice (e.g., integrated mental health,
ix. Healthy Steps, Medical-Legal Partnerships, Reach Out and Read, Project DULCE).
x. Additional measurement and framework resource: https://www.ahrq.gov/sites/default/files/publications/files/ccm_atlas.pdf

j. MCOs can incentivize Medical Home transformation by:
    i. Incentivizing NCQA certifications (or other evidence based certification programs)
    ii. Offer meaningful Medical Home technical assistance to practices (meaningful being a technical assistance that provides orientation to the MH Model and paths to certification, suggested methods of operationalizing MH, and mentorship throughout the process from a certified consultant.
    iii. Reimburse for care coordination codes- either for all practices or for a select few (ex: those who have designated care coordinators or LCSW's providing BH interventions.)
    iv. Incentivize combined initiatives for Behavioral health and Medical Home. Ex: those having LCSWs provide both behavioral health interventions and care coordination services.
    v. Recommend the use of family feedback for quality improvement. (We recommend the CAHPS Clinician & Group Patient-Centered Medical Home Survey 2.0 Found here: https://www.ahrq.gov/cahps/surveys-guidance/cg/pcmh/index.html.)
k. MCOs could suggest triaging by requiring/incentivizing the use of the national Children and Youth with Special Health Care Needs screener: http://www.cahmi.org/projects/children-with-special-health-care-needs-screener/ and http://www.cahmi.org/wp-content/uploads/2014/06/CSHCNS-Fast-Facts.pdf

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

a. Members should experience care equity. That means that regardless of plan, members should expect to receive the same baseline level of care across the board.
b. Many members have multiple individuals coordinating their care, health plan case managers, home visitors, DCFS caseworkers, social workers, etc. Coordination between these individuals providing case management services should be encouraged to increase data sharing, decreasing duplication, and improving outcomes. The health plan may not always be the best entity to be the "hub" of a member's care coordination; in these cases the MCO should be contracting with other entities to provide these services.
c. MCOs should look at the whole person when addressing/managing chronic diseases to identify underlying causes related to Social Determinants of Health, including mental health and wellbeing as well as trust of medical provider.
d. MCOs must show a commitment and have concrete plans in their response to the RFP to embed an equity focus to their internal work. This could include:
    i. Staff training on social determinants of health, particularly systemic inequity that leads to health disparities (i.e., Undoing Racism workshop, implicit (unknown) bias training, etc.)
    ii. Utilize equity impact assessments for decision making, like this one: https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf. While it is specific to racial equity, the framework can be applied to

assess the impact on equity in other areas like class, language, ability, sexuality, etc.

iii. Staff training could apply to state Medicaid monitoring and quality staff as well.

e. MCOs must make a focused effort to recruit, develop, and retain a diverse staff, striving to eliminate opportunities for unknown/known bias. These efforts should be described in their response to the RFP with specific goals and in turn progress should reported to the state regularly

f. MCOs must utilize equitable language in internal and external communications (this document might be helpful even though it is media-focused: https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf)

g. MCOs must show a commitment and have concrete plans to engage community members in data collection, analysis, and dissemination and in key decision/planning points. They should train their staff on how to effectively and respectfully engage communities, and/or hire community/family representatives (parent liaisons, etc.)

i. MCOs should propose and implement (possibly as a pilot study) innovative solutions to issues related to the social determinants of health such as substandard housing, transportation, food insecurity, and community violence. Results should be publicly reported on.

h. MCOs must establish communication/partnership with other sectors outside of the clinical setting related to health (housing, transportation, education, employment, faith-based orgs, etc.) in order to build cross-sector solutions.

i. This resource from GARE is also really helpful in breaking down key steps to starting racial/health equity work—the language here may help inform what to ask for and look for from the MCOs: https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf

j. Use the following tool during the RFP process to incorporate health equity as much as possible into the whole proposal and contracting process: https://asphn.org/wp-content/uploads/2018/01/Health-Equity-Language-Checklist.pdf

k. ACOG recently released a Committee Opinion on the importance of social determinants of health and cultural awareness in the delivery of care. MCOs have the opportunity to support provider implementation in the delivery of care. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Importance-of-Social-Determinants-of-Health-and-Cultural-Awareness-in-the-Delivery-of-Reproductive

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

a. Incentivize behaviors backed by evidence such as reducing mortality rates and/or improving quality of life and provide incentives that help the member implement that behavior. For example, having a safe infant sleeping environment reduces infant mortality, so if someone is pregnant and goes to prenatal care, MCOs can become partners with Cribs for Kids to offer pack-and-plays, car seats, or a stroller to the parent as an incentive for another part of pregnancy care that can also reduce cost, such as adequate prenatal care.

b. MCOs should partner with programs and agencies that provide incentives at bulk rates to the MCOs such as the Cribs For Kids example above.

c. For equity purposes, find out what is a meaningful incentive from the population being served – conduct local and regional focus groups instead of leaving the decision up to the marketing department or national parent company.
d. Consider which other services members access and how could they be tied to behavioral economic incentives to improve patient compliance. Would things such as bus passes, child care, "slots" in services, additional dollars loaded on SNAP cards, etc. be better supports for members?

11. Improve Approach to Value-added Benefits

a. Medicaid should consider providing a list of initiatives from other relevant state agencies such as OPH, DCFS and Workforce Development that would be supported by additional resources through value added benefit programs. For example, breast pumps to support breast-feeding, cribs to support safe sleep, job search assistance to support employment, etc.
b. Medicaid should consider if there is a minimum standard of value added benefits that all members should receive. Suggestions include:
    i. Dental care for adults
        1. dental hygiene also impacts social determinants of health, such as the ability to gain employment
    ii. Breast Pumps
        1. Current process of MCO referrals to WIC for breast pumps is inadequate; yields low utilization and presents many barriers to continued access.
    iii. Continuous Glucose Monitoring Systems (CGMs) for Type 1 Diabetics
        1. The Endocrine Society recommends CGMs as the gold standard of care for both children and adults with Type 1 diabetes.
    iv. Hearing services for all ages such as exams, screening and treatment, hearing aids, and translation and on-site interpreter services upon request.
c. There should be no reason to limit value added benefits if there is no cost to the state; this needs to be looked at as one of the benefits of managed care over Fee for Service.

12. Achieve Administrative Simplification

a. MCOs should not be allowed to interpret the Medicaid provider manuals differently. If Prior Authorizations must continue to be used, then they should all utilize the same ones across the board to reduce variance.
b. Family Planning should not be considered separate from the rest of the Medicaid Provider Manuals by the Plans and up to the plans for interpretation. For example, some of the plans continue to refer to the old Take Charge waiver, which only covered women. Medicaid could streamline the manuals to make it easier for the plans and therefore the providers.
c. In addition to member satisfaction and health outcomes, provider satisfaction with the MCOs and the Medicaid program is critical to program success. Providers should be regularly surveyed by both MCOs and Medicaid to identify areas for improvement in the relationship. These surveys should be publically available and potentially tied to incentive payments. Additionally, a more robust system needs to be developed by Medicaid for providers to report challenges with MCOs and should include prompt follow up and communication back to the complainant.