UnitedHealthcare
Community Plan

3838 N Causeway Blvd
Suite 3225
Metairie, LA 70002

April 17, 2018

Louisiana Department of Health
Office of the Medicaid Director

RE: White Paper, Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care

UnitedHealthcare Community Plan appreciates the opportunity to respond to the Louisiana Department of Health, Office of the Medicaid Director's White Paper regarding the future of its Medicaid managed care program. We have served the State in the Medicaid managed care program since 2012 and have seen firsthand the continued improvements the Department has brought to this vulnerable population. With the 435,000 Louisianans we serve in the State today through Medicaid Managed Care, we have a deep appreciation of the unique needs of the population within each Parish, as well as an in-depth understanding of the provider community serving this population. We also bring a perspective across the national landscape, serving 6.7 million individuals in Medicaid and 630,000 in duals special needs plans across a total 34 states.

Our comments on the White Paper are included in the following pages. Should you have any questions or seek further information, please do not hesitate to contact me at (504) 849-3520 or allison_young@uhc.com.

Sincerely,

Allison J. Young
CEO and President, Louisiana Community Plan

As required per the White Paper, this response is submitted by **UnitedHealthcare**, an **Insurer** operating **Statewide** in Louisiana.

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UnitedHealthcare Community Plan

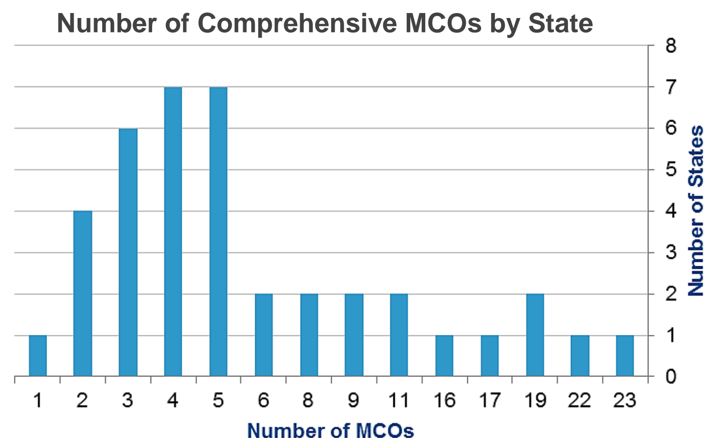
INTRODUCTION

UnitedHealthcare appreciates the opportunity to respond to the Louisiana Department of Health (the "Department") as part of its *Paving the Way to a Healthier Louisiana* White Paper. The Department has taken great strides in improving experiences and outcomes for Medicaid recipients in the State through the Healthy Louisiana program. We look forward to continued collaboration with the Department as it looks for opportunities to transform Medicaid Managed Care in the State. Through this response we offer our feedback to the Department's proposed program redesign, informed by lessons learned and best practices across the 26 states and 6.7 million individuals we currently serve through Medicaid nationally, as well as our local experience in and appreciation of the Louisiana market.

RESPONSE

Limit the Number of Statewide MCOs

We recognize and appreciate the Department's focus on efficiency and administrative simplification as it contemplates reducing the number of managed care organizations (MCOs) participating in the Healthy Louisiana program. We do not support an increase in the number of MCOs. However, Louisiana is consistent with the number of MCOs in states across the US, as can be seen in the graphic.[1]



We support the existing program and recommend the Department not contract with fewer than 3 MCOs to preserve member choice, MCO competition, and innovation. We also encourage the Department to focus on quality and member satisfaction if it reduces the number of MCOs serving the Medicaid population, ensuring that these are key considerations in the reprocurement.

Expect MCOs to Operate as Innovators to Achieve the Triple Aim

MCOs have the ability to achieve innovation across the delivery system. For example, working closely with providers, MCOs are well positioned to provide continuous quality improvement and improve care and population health through the use of value-based payment (VBP) arrangements. This can be achieved by incorporating measures and incentives into VBP based on health outcomes and the provision of evidence-based care. As the Healthy Louisiana program matures, providers are becoming increasingly sophisticated in their ability to participate in VBP arrangements, and we encourage the Department to ensure MCOs have the flexibility to

[1] Kaiser Family Foundation. Total Medicaid MCOs, Sept 2017. Data reflect only capitated MCOs providing comprehensive services to Medicaid beneficiaries.

work with providers to design the VBP arrangement that works best. Additionally, MCOs are able to provide supports to providers not participating in VBP arrangements, facilitating program performance among these practices and also creating a framework that facilitates their shift to VBP, supporting the State's broader goals.

As discussed throughout our response, other State and MCO opportunities include telehealth expansion, paramedicine, physical and behavioral health integration, social determinants of health, behavioral economics, and analytic tools that can reduce costs, and redirect and encourage better health choices by members. These approaches and their outcomes are in line with the Choosing Wisely concept.

Enhance Network Adequacy and Access Standards

Also discussed in the section below, flexible telemedicine policies and fee schedules can facilitate access to care in underserved areas as well as for individuals who may otherwise be limited in their ability to travel to a provider. While we understand MCOs are not limited to the State's fee schedules, we encourage the Department to enable the use of unused VAB/VBP dollars to encourage new innovations including but not limited to behavioral economics programs, telehealth supplemental payments, and mobile applications to improve access.

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

In addition to our responses provided elsewhere, we recommend several strategies the Department might take to promote access to care:

- To promote practice transformation toward primary care medical homes, it will be important to ensure primary care practices have the necessary resources, including data supports and infrastructure as well as appropriate reimbursement. MCOs can provide value-based payment incentives to further support providers acting in this capacity.
- To maximize the benefit of telemedicine, we recommend that the Department expand reimbursement allowed for these services, specifically allowing reimbursement for services occurring at the originating site as well as for store and forward technologies. Additionally, to ensure adequate access to providers treating patients through telehealth, Louisiana should facilitate pathways that allow inter-state licensure for health care professionals and ensure that providers' current licenses allow for extended reach beyond state lines to better serve local health care needs. This may include allowing out-of-state providers to seek and receive special exemption from the State Medical Board to treat Medicaid beneficiaries via telehealth, particularly where there may be shortages of key provider types within the State. Additionally, telehealth coverage should be consistent with Medicaid, medical board, and state statute related to coverage for health services provided through in-person consultation. Telehealth requirements should be no more restrictive than in-person coverage requirements to allow beneficiaries to receive appropriate care based on established clinical standards across all medical specialties.
- To facilitate a shift away from unnecessary use of the emergency department (ED) and ensure access to more appropriate care, we encourage the Department to allow MCOs

flexibility to design benefits around and reimburse for in-home delivery of services. In-home care also can prevent unnecessary hospitalizations and ambulance transfers, particularly for high-risk, complex individuals.

- Mobile Integrated Healthcare or Community Paramedicine (MIH-CP) is an innovative and evolving model of community-based healthcare designed to provide effective and efficient services at a lower cost. MIH-CP allows emergency medical technicians to employ their skills and training beyond traditional emergency response and transport roles to help facilitate more appropriate use of emergency care resources while enhancing access to primary care for medically underserved populations. Under these models emergency medical technicians provide outpatient urgent and extended primary care services for patients who might otherwise visit or be transported to the ED. We encourage the Department to provide coverage and allow reimbursement for MIH-CP. The State also should formally recognize community paramedics as a distinct provider type, designating licensure and education requirements to define their scope of practice.

Improve Integration of Physical and Behavioral Health Services

In December 2015, Louisiana made an important change to the way behavioral health is managed in the Medicaid program, carving these services into the broader Healthy Louisiana program. This program design sets a foundation for the Department to build on and promote additional behavioral health/physical health integration. For example, VBP design can be leveraged to promote whole-person care and virtual clinical level integration by developing incentives that address both behavioral health and physical health outcomes. Additionally, MCO ability to leverage integrated member assessments, a single care management platform, integrated care management teams, and blended risk stratification can drive virtual clinical level integration.

As discussed in more detail below, we encourage the Department to allow MCOs to retain flexibility in developing VBP models to ensure MCOs can create arrangements that accommodate provider readiness to participate. MCOs are positioned to provide necessary data and outcomes-based incentives to promote clinical-level integration of behavioral and physical health, and should be ready to support providers in the use of broad data sets.

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

UnitedHealthcare has considerable experience working with providers through VBP arrangements, including $64 billion spent in 2017 as part of VBP arrangements across our Medicare, Medicaid, and Commercial products. Through this experience we have learned that one size does not fit all; provider practices have varying levels of readiness to participate in these arrangements. We support the Department’s focus on common quality measures, reporting tools, and frequency of reports. We also support moving up the HCP-LAN continuum to shift away from non-risk based PMPMs not directly tied to quality. We recommend the following design features as the Department continues to advance VBP in the Healthy Louisiana program:

- The Department should provide MCOs with sufficient flexibility to accommodate varying levels of practice sophistication, patient characteristics, preparedness, and willingness to enter into alternative payment arrangements. With this flexibility, MCOs can develop models that meaningfully engage providers, informed by a provider's experience, resources, and sophistication, and can facilitate development of strategic partnerships that align with practice goals and interests and limit provider financial exposure.
- The incentive structure that motivates one provider to engage meaningfully in a value-based arrangement will not necessarily motivate all other providers. The Department should ensure MCOs have the flexibility to work with providers to understand their motivations, pain points, and opportunities to design reimbursement structures that drive value for the provider, and design the incentive structure accordingly.
- We encourage the use of Episodes of Care as a vehicle to improve quality, manage costs, and improve outcomes. This will enable the organic expansion of VBP to specialists and facilities.
- The Department should ensure MCOs have sufficient flexibility to determine strategic partnerships with downstream contractors to allow for an approved range of delegated activities. Strict prohibition or arbitrary mandates forcing relationships can create system inefficiencies and potentially limit the movement to increase payment under VBP arrangements.
- Any VBP benchmarks should be based on the percent of Medicaid members rather than a volume of providers or dollars spent, to develop meaningful incentives for practice transformation. Focusing on percent of members allows VBP models to be PCP focused. A focus on spend or number of providers forces VBP expansion to providers that tend not to be appropriate for total cost of care models or that are not yet ready to participate in VBP arrangements.

We also direct the Department to our response provided to the November 2016 Request for Information for Provider-Led Accountable Care Organizations regarding the respective roles of MCOs and accountable care organizations (ACOs), particularly as accountability shifts increasingly to the delivery system.

Promote Population Health

A successful population health strategy should be informed by data including healthcare utilization and social determinants of health. As discussed below in our response to improving health equity, we recommend the Department ensure and improve comprehensive data accessibility to allow for appropriate program coordination and linkages across an individual's whole experience. The Department should serve as an aggregator of necessary data feeds related to social services and social determinants of health and provide this aggregated feed to MCOs to combine with health utilization data to develop a robust population health strategy. Additionally, the Department can work with MCOs to identify performance improvement projects (PIPs) targeting specific population health goals and potentially, priority social determinants of health to the extent these efforts are funded and data driven. MCOs can couple this approach

with the Department's focus on leveraging community health workers and enhanced care coordination (discussed in the following section).

Population health management also runs hand-in-hand with VBP strategies and MCOs should be encouraged to include population methods and outcomes in their VBP arrangements with providers. However, as noted throughout our response, we caution against prescribing VBP contracting requirements as providers vary in their willingness and ability to participate in these arrangements and to drive population health at a clinical level. MCOs should be able to work with provider practices to design an arrangement that works for the provider while promoting improved outcomes, accountability, and population health.

The more comprehensive a managed care program is, the better opportunity MCOs have to drive improvements in population health, as they can serve the "whole person" and the whole Medicaid population. To the extent the Department maintains population or service-based carve-outs, these carve-outs should inform the State's Medicaid Managed Care Quality Strategy and population health metrics. MCOs will be limited in the tools they can provide as a result of program carve-outs and the Department should ensure that any population health quality measurement accounts for this.

Improve Care Management/Care Coordination at MCO and Provider Levels

We support the Department's emphasis of improved care management and care coordination across both MCOs and providers. MCOs should have flexibility to leverage non-traditional providers such as peer supports, community health workers, and home visiting services to facilitate this coordination, and these providers' services should be reimbursable through Medicaid. This approach maximizes the allocation of resources, improves outcomes, and is more effective in addressing the physical, behavioral, and socioeconomic needs of the population thereby improving the efficiency of the entire program.

MCOs should be able work closely with providers to determine which evidence-based solutions are most beneficial for each individual, based on that person's risk level. To inform an appropriate and risk-specific care management solution, we encourage the Department to allow MCOs to leverage data analytics and innovations such as new mobile technologies. For example, rather than screening healthy members annually as a standard, MCOs can monitor member utilization of services systematically by notifying the MCO clinical team of a change in the member's health status due to an emergency room visit, inpatient stay, lack of engagement with their primary care doctor as recommended, or through home monitoring devices. We also recommend effective transfer of real time data through provider and MCO data exchange (admission, discharge, and transition files) to allow for earlier identification and engagement of members to coordinate timely interventions to maximize impact, improve quality, and prevent unnecessary costly utilization. Typical strategies to mine claims data only offer a retrospective view of the individual's engagement with the health care system and minimal opportunities to impact.

Additionally, as addressed below, member incentives/behavioral economics can be a useful tool to support effective care management and care coordination, for example by allowing MCOs to provide incentives to members for the completion of the health risk assessment (HRA).

Increase Focus on Health Equity and Social Determinants of Health

An individual's social determinants of health (SDOH) are responsible for a significant portion of their well-being and health outcomes, with research suggesting social and environmental factors have twice the impact on premature death that health care does.[2] Social determinants drive health inequities through creating barriers to affordable and safe housing, healthy foods, and other critical resources. To that end, we encourage the Department to create a framework for MCOs to innovate on top of, for example the Department should identify opportunities to increase the availability and quality of affordable housing in the State.

Louisiana is positioned to address social determinants by leveraging MCOs as a bridge across healthcare and social services. For this to be successful, we recommend the Department incorporate existing social services financing and expertise into the Medicaid program through strategies such as:

- Explore opportunities to pilot streamlined program financing across health care and social services (e.g., provide a pooled/single payment inclusive of health and social services funding to MCOs with the State managing the inter-agency collaboration to braid the funding on the backend). This approach prevents cost shifting across services, promotes program sustainability, reduces administrative burdens, affords synergies across the various partners, ensures care continuity, and improves patient experiences. When effectively designed it also allows for all agencies to share in the system savings achieved through the holistic management of health and social services and offers opportunities for re-investment if programs are successful in achieving cost savings. The most effective systems have aligned priorities at the Governor's level, which focuses the local, regional, and state program investments and coordinates the system transformation with priorities and goals across agencies.
- Improve SDOH data accessibility to allow for appropriate program coordination and linkages across an individual's whole experience. SDOH data is often unavailable or unlinkable to healthcare data as a result of variable eligibility pathways, program resources, data infrastructure, and data collection methods. Targeting state resources to bring consistency to data collection and storage methods (e.g., a common population health platform) across social service programs, and ensuring the collection of sufficient information will afford the opportunity to test interventions and predictive analytics to target limited resources to individuals based on combined need.
- Improve medical coding of social determinants of health through health care provider education. The current ICD-10 medical coding system includes Z-codes that allow providers to denote specific issues such as homelessness, lack of adequate food, and unemployment. More accurate coding of these issues within the health care system will

[2] Schroeder SA. (2007). We can do better—Improving the health of the American people. NEJM. 357:1221-8.

allow the State and MCOs to better understand population needs and implement targeted solutions, including adjusting provider panel size and staffing differently for team-based care.
- Ensure MCOs have a clear pathway to connect members to necessary services in a timely manner as SDOH needs are identified, for example, aligning expecting mothers with the WIC and SNAP programs. Similarly, the State should use SNAP data as a fast-track eligibility option to enroll eligible individuals into the Medicaid program.

Additionally, as part of the next procurement, the Department should consider the extent to which MCOs are able to use data to identify complex members as well as leverage partnerships across the State and local continuum of care to cultivate affordable SDOH solutions.

Apply Insights from Behavioral Economics to Facilitate Enrollees' Health Behaviors and Choices

Behavioral economics research suggests that incentives, if designed appropriately, can influence health behaviors and choices. For example, incentives designed as rewards, provided at the point of service, and tied to one-time events have been found most effective in encouraging positive lifestyle change. [3]

The Department should continue to permit incentives as one method in MCOs' broader toolkits to improve health outcomes, and MCOs should be provided flexibility to structure these incentives based on the needs of the population. This approach can promote the Department's broader goals around population health, health equity, and care management, for example by incentivizing HRA completion and healthy behaviors, and preventing missed appointments.

Because incentives designed as penalties can have adverse effects such as increased emergency department use,[4] incentives should be reward-based and might include money-valued incentives (e.g., debit cards, catalog points, flexible spending accounts) or incentives such as transportation, child care, baby supplies, exercise equipment, etc.

Improve Approach to Value-added Benefits

Value-added benefits can be a strong tool in allowing MCOs to address critical needs of a population that otherwise may not be covered through a program, such as certain social services related to health inequity and SDOH and/or innovative programs to modify member behavior through behavioral modification/economics initiatives. We encourage the Department to continue allowing for the provision of these services using an approach that supports greater flexibility.

Additionally, MCOs have the ability to offer value-added supports to providers through approaches such as infrastructure building and continuing education opportunities. These approaches serve to expand access to care, improve efficiencies in the system through reduced

[3] https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf
[4] https://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes

administrative burdens, and decrease provider costs associated with practice management activities. MCOs should be able to continue providing such value-added supports to providers.

Achieve Administrative Simplification

We appreciate the Department's goal of reducing administrative burdens associated with the managed care program. We believe that centralizing transactional, utility functions, such as provider credentialing and data intake forms, can be effective at meeting a program's goals while preventing unnecessary duplication of efforts by providers and MCOs but caution that it also can add costs to a program when streamlining is overly prescriptive. As the Department contemplates what program components to streamline and centralize, it will be important to ensure MCOs retain their ability to use proprietary tools, develop innovative approaches to meet the evolving demands of the Medicaid system, and deliver care management models that afford improved health outcomes as well as program cost savings.

Additional program design features that can minimize administrative burden include the following:

- Ensuring practitioners are able to practice at the top of their license, to maximize the time of physicians in rendering care
- Promoting electronic connectivity across programs serving Medicaid members
- Reducing redundancy in reporting and data entry
- Encouraging providers to leverage technology to minimize unnecessary manual work (e.g., using health ID card magnetic strips to extract information; reducing redundancy in health information intake for patients)

SUMMARY

The Department has envisioned a number of strategies that collectively can promote population health, more holistic care management, and administrative efficiencies. We look forward to continued collaboration with the Department and Healthy Louisiana providers in serving the Medicaid population. We are happy to provide additional information or clarification on any points made in this response.