To Whom It May Concern:

Well-Ahead Louisiana, an initiative of the Bureau of Chronic Disease Prevention and Health Promotion within the Louisiana Office of Public Health, submits the following feedback to the Louisiana Office of Medicaid in response to the "Paving the Way to Healthier Louisiana: Advancing Medicaid Managed Care" white paper. We appreciate the opportunity to review and provide feedback. If there are any questions regarding this feedback, please contact wellahead@la.gov.

Re: Response to Medicaid White Paper Section III. b. "Expect MCOs to Operate as Innovators to Achieve the Triple Aim"

The scope of Well-Ahead Louisiana includes programs focused on several chronic diseases, including oral health promotion, tobacco prevention and cessation, diabetes prevention and management, and heart disease prevention and management. Well-Ahead promotes the implementation of several evidence-based practices recommended by the Centers for Disease Prevention and Control that have been demonstrated to improve care and health outcomes. The positive impact on patient health outcomes, as well as the cost-effectiveness of these preventive measures, has been shown in various settings.

Suggestions to increase MCOs ability to achieve the Triple Aim in regards to chronic disease health outcomes:

1. Add evidence-based best practices that address chronic disease to the list of recommended services for MCOs to cover as value-added benefits. The chart below provides additional detail on each of these best-practices and their potential impact.

Recommended Service/Coverage	Potential Cost Savings	Impact on Patient
• Cover all 7 FDA approved cessation medications • Provide barrier free individual and group counseling • Offer coverage for state Quitline services	• July 2015 to December 2016- 28.5 percent of quitline callers were from Medicaid fee-for-service[1] • Medicaid is able to claim 50% Federal Financial Participation (FFP) match-funds on the administrative costs for the Quitline to serve these patients	• Limits on the number and durations of treatments, copays, and referrals from a patient's provider are examples of barriers that impede or delay access to treatment.
• Educate/encourage providers to apply fluoride varnish	• It's about 10 times more expensive to provide inpatient dental care for caries-related conditions than to provide preventive care.	• Early oral health prevention and promotion is significant to reducing disease burden and increasing overall quality of life. • Tooth decay can be prevented, yet 1 in 4 children have had tooth decay by age 5. Children of color have higher rates of tooth decay.

• Coverage of home blood pressure monitors to promote Home Blood Pressure Monitoring (HBPM)	• Estimated net savings associated with HBPM:
	  • $33-$166 PM/PY
	  • $415-$1,364 PM over ten years
	• ROI:
	  • $0.85-$3.75 per dollar in first year
	  • $7.5-$19.34 per dollar over ten years
		• HBPM can produce a more accurate BP that "predicts risk better than office measurements"
		• HBMP, paired with additional clinical support, "enhances the BP-lowering effect"
		• HBPM has been shown as a significant predictor of CV mortality and CV events

• Increase access to Diabetes Prevention Programs (DPP)	• In 2014, the Medicaid MCOs paid approximately $4,061,261.40 for diabetes-related inpatient hospitalizations. • Since type 2 diabetes accounts for 90-95% of all diagnosed cases in adults, supporting lifestyle change programs could significantly reduce healthcare cost over time.	• Research shows that people who participate in this lifestyle change program cut their risk of developing type 2 diabetes by 58%. This is a result of the program helping people lose 5% to 7% of their body weight, eating healthier and getting 150 minutes of physical activity per week.

• Coverage for Dietitian Obesity Counseling
• Intensive Behavioral Therapy (IBT)
	• Cost:
	  • Medicare and Medicaid patients with obesity annual cost per year:
	  • $61.8 billion
	• Savings: (from preventative and community based programs)
	  • Medicaid - $1.9 billion
	  • Medicare - $5 billion
	• 15 percent cost savings associated with PCP visits
		• Appropriate nutrition education on healthy eating and behavior habits
		• Increases a patients nutrition knowledge and how to maintain a healthy weight
		• Improvements in BMI, lipid levels, glucose level and adipose tissue
		• Decreases risk for chronic diseases

Citations:

- *Singleberry, J., Jump, Z., Lancet, E., Babb, S., MacNeil, A., & Zhang, L. (2014). State Medicaid coverage for tobacco cessation treatments and barriers to coverage- United States, 2008-2014. Morbidity and Mortality Weekly Report, 63 (12), 264-269.*

- *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents, Dept. of Health and Human Services, Centers for Medicare & Medicaid Services*
- *Pickering TG, Miller NH, Ogedegbe G, Krakoff LR, Artinian NT, Goff D; American Heart Association; American Society of Hypertension; Preventive Cardiovascular Nurses Association. Call to action on use and reimbursement for home blood pressure monitoring: a joint scientific statement from the American Heart Association, American Society Of Hypertension, and Preventive Cardiovascular Nurses Association. Hypertension. 2008;52:10–29.*
- *NIH Publication No. 09–5099 October 2008 Diabetes Prevention Program (DPP)*
- *The Cost of Obesity. Academy of Nutrition and Dietetics. http://www.eatrightpro.org/resource/advocacy/disease-prevention-and-treatment/obesity-and-weight/the-costs-of-obesity*
- *The State of Obesity. Better Policies for a Healthier America. http://stateofobesity.org/healthcare-costs-obesity/*

2. Increase reimbursement rate for Diabetes Self-Management Education. Evidence shows that people who participate in DSME programs have lowered their A1C, have fewer hospital admissions, and fewer emergency room visits. An economic analysis reported that for every $1 spent on DSME, there was a net savings of $0.44 to $8.76. Louisiana Medicaid reimbursement currently lags behind regional rates and Federal Medicare rates.

DSME Reimbursement Rate Comparison Table

Code	Medicare	Louisiana Medicaid	Mississippi Medicaid	Kentucky Medicaid
G0108	$51.60	$15.20	$45.05	$50.50
G0109	$13.88	$8.55	$12.13	$13.92

Citation: Costs and Benefits Associated with Diabetes Education: A Review of the Literature. Boren, Fitzner, Panhalkar, Specker. The Diabetes Educator 2009; 35;72.

3. Request additional information related to Medication Therapy Management (MTM) programs. Currently each MCO is required to have an MTM program, but reimbursement is negotiated directly with pharmacists or third-party vendors, so rates and eligibility may vary. This makes it less attractive to pharmacists, as it is difficult for them to determine which patients they can provide MTM to and be reimbursed. MTM can lead to improved patient adherence and utilization of medications; increased percentage of patients meeting their treatment goals (e.g., blood pressure, blood glucose, cholesterol); reduced drug duplication, harmful side effects, or interactions between medications, vitamins, and supplements. MTM can lead to greater medication cost savings, and medical resource cost savings (e.g., fewer emergency department visits), due to more effective use of drug therapy.

Citation:

- *Potential cost savings of medication therapy management in safety-net clinics.* ***http://www.japha.org/article/S1544-3191(15)30058-3/fulltext***
- *Increasing Medicare Part D Enrollment in Medication Therapy Management could Improve Health and Lower Costs. http://content.healthaffairs.org/content/32/7/1212.abstract*

4. Include a requirement for MCOs to encourage Collaborative Practice Agreements between providers and local pharmacies. These CPAs empower team-based, patient-centric care. A 2010 study found that patient health improves significantly when pharmacists work with doctors and other providers to manage patient care; significant findings for improvements in medication adherence, patient knowledge, and quality of life-general health. Patient care services provided by pharmacists can reduce fragmentation of care, lower health care costs, and improve health outcomes. These include: reduced hospitalizations, ER visits, reduced outpatient visits, direct cost-savings to the patient.

Citation:

- *Chisholm-Burns MA, Kim Lee J, Spivey CA, Slack M, Herrier RN, Hall-Lipsy E, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. Med Care. 2010;48:923–33.https://www.ncbi.nlm.nih.gov/pubmed/20720510*
- *Chisholm-Burns MA, Kim Lee J, Spivey CA, Slack M, Herrier RN, Hall-Lipsy E, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. Med Care. 2010;48:923–33. https://www.ncbi.nlm.nih.gov/pubmed/20720510*

Re: Response Medicaid White Paper Section III g. What requirements should be placed on MCOs in terms of utilizing a population health approach to care delivery? What are the key aspects that should be included within a population health strategic plan?

Suggestions for key aspects to be included within a population health strategic plan:

Well-Ahead recommends that any Population Health plan emphasize the importance of community-clinical linkages as a key component in the prevention and control of chronic disease (https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf). The CDC's National Center for Chronic Disease Prevention and Health Promotion promotes community-clinical linkages to help "ensure that people with or at high risk of chronic diseases have access to the resources they need to prevent, delay, or manage chronic conditions once they occur." Clinical outcomes related to heart disease, diabetes, and blood pressure, among others, can benefit from these partnerships. Similarly, positive lifestyle behavioral changes such as nutrition, physical activity, and smoking cessation levels have been documented.

Suggestions for requirements to be placed on MCOs for utilizing a population health approach to care delivery:

Well-Ahead recommends MCOs be required to work with their provider networks to assess barriers to collaboration with community organizations, at a minimum establishing referrals to

lifestyle behavior programs (National Diabetes Prevention Program, Diabetes Self-Management Education Programs, Chronic Disease Self-Management Programs). Well-Ahead can provide assistance with addressing barriers and establishment of additional programs. MCOs should establish referral protocols with these organizations which will lead to sustainable access .

Re: Response Medicaid White Paper Section III h: Please provide your opinion on whether MCOs should be required to employ, support, and/or utilize Community Health Workers for certain populations and care management interventions? Please elaborate.

Well-Ahead supports a requirement for MCOs to employ Community Health Workers to support chronic disease care. CHW's are a key component of Population Health, as they serve a unique role in establishing community-clinical linkages. CHWs' effectiveness in promoting primary and follow-up care for preventing and managing disease, have been extensively documented and recognized for a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV and AIDS. (*citation: http://www.cdc.gov/dhdsp/docs/chw_brief.pdf).* The cost-saving potential of CHWs has been demonstrated, with some settings seeing as high as 3:1 net ROI. The CHW serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. (*citation: https://www.apha.org/apha-communities/member-sections/community-health-workers)* CHWs can serve as members of the primary care team, patient navigators, organizer or patient advocate, or providing outreach and enrollment for programs or services. In any of these roles, the CHW can provide feedback to the primary care team that enables the care plan to be more appropriately tailored to the patient's needs. The range of capacity allows for MCOs to tailor their CHW program to meet the needs of their patients. Requiring the use of CHWs will therefore not be overly restrictive. CHWs, as trusted community members, will increase the capacity of the MCO to connect patients to community resources that can go beyond direct clinical follow-up and assist the patient in addressing social determinants of health.

Re: Response to Medicaid White Paper Section i. Increase Focus on Health Equity and Social Determinants of Health

The Centers for Disease Prevention and Control (CDC), defines health equity as the attainment of the highest level of health for all people.[1] Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.[1]

Aside from finding more effective ways to deliver traditional medical care and instituting population health approaches in identifying subpopulations experiencing health disparities[2], research

[1] Centers for Disease Control and Prevention-Division of Community Health. (2013). A practitioner's guide for advancing health equity: Community strategies for preventing chronic disease. Atlanta, GA: US Department of Health and Human Services.

[2] Louisiana Department of Health-Bureau of Health Services Financing. (2018). Advancing Medicaid managed care: Future vision and policy considerations for public engagement.

demonstrates that improving populations health and achieving health equity will also require approaches that address social, economic, and environmental factors that influence health.[3] These factors that influence health can include but limited to socioeconomic status, education, neighborhood environment, employment, social support as well as access to health care.[3]

Suggestions to increase MCO focus on social determinants of health and improve health equity.

- Leveraging Home & Community-Based Services (HCBS)[4]
    - A home and community-based approach can routinely ensure providers consider an enrollee's living in environment, coordinate care, and provide care beyond the office/clinic/acute care setting increasing the focus on nonmedical factors that influence health and quality of life.
    - Home and community-based approach is shown to be cost efficient with better outcomes than institutional care.
    - Care coordination and case management "hot-spotting" to bridge or improve care coordination connecting individuals and their communities to reduce-prevent health episodes and improve quality of life.
    - **Strategy:** Managed Long-Term Services and Supports (MLTSS), holding providers accountable through performance-based incentives or penalties through realignment to support the scope of broader health and community.
    - **More information on Strategy:**
        - http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/machledt_social_determinants_medicaid_managed_care_ib_v2.pdf

- Identifying nonclinical health risks and social needs with targeted providers
    - Within the LA Medicaid White Paper, an emphasis was placed on requiring MCOs to collaborate with high volume providers to develop, promote and implement targeted evidence-based interventions for sub-populations experiencing health disparities,[2] adding nonclinical questions can help identify health risks not traditionally captured in a standard clinical evaluation.[4]
    - For example, routine screening for food security, screening for domestic abuse, housing stability, etc.[4]
    - **Strategy:** Placing requirement of MCOs to implement alternative payment models (APM) for targeted providers. Alternative payment models requirement can invest in practices that connect health with nonmedical factors such as those identified in the LA Medicaid White Paper.
    - **More information on Strategy:**

[3] Heiman, H.J., & Artiga, S. (2015). Beyond health care: The role of social determinants in promoting health and health equity. *Kaiser Family Foundation Issue Brief*. Retrieved from: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[4] Machledt, D. (2017). Addressing the social determinants of health through Medicaid Managed Care. *The Commonwealth Fund Issue Brief*. Retreived from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/machledt_social_determinants_medicaid_managed_care_ib_v2.pdf

    - http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/machledt_social_determinants_medicaid_managed_care_ib_v2.pdf

- Rulemaking to support MCO to cover nontraditional services, social interventions, population health inventions[4,5]
    - **Strategy(ies):**
        - "In-Lieu-Of" which can count toward capitation rate-setting and services side of medical loss ratio (MLR). Substituting for services covered in state plan because of cost effectiveness.
        - Value-added services which can count as services for purposes of MLR-removing potential disincentive for plans to cover social interventions.
        - Incentivizing or withhold to encourage plan investment in social interventions and quality metrics linked to specific population health interventions
    - **More information on Strategies:**
        - http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/machledt_social_determinants_medicaid_managed_care_ib_v2.pdf
        - http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting

[5] Machledt, D. (2017). Addressing the social determinants of health through Medicaid Managed Care. *The Commonwealth Fund Issue Brief*. Retreived from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/nov/machledt_social_determinants_medicaid_managed_care_ib_v2.pdf