WELLCARE INTRO TO LOUISIANA

WellCare of Louisiana is honored to provide feedback as the Louisiana Department of Health (LDH) continues enhancing Healthy Louisiana and prepares for the next procurement. As a Medicare and Duals Special Needs plan serving 40,000 Louisianans, we have watched closely as the program has evolved and, based on our extensive experience in similar programs across the nation, we have seen the opportunity for Managed Care to improve health care for Louisiana's Medicaid enrollees. With the state's expansion of Medicaid and as more members have had access to critical preventive care, we continue to see new opportunities to enhance Member quality of life, reduce administrative burden on providers, stabilize spending and streamline member access to care while improving population health. As a wholly-owned subsidiary of WellCare Health Plans, which serves 2.7 million Medicaid members across 11 states, we know what it takes to drive real change on behalf of Medicaid members.

WellCare is dedicated to serving members in government-sponsored health care. With this specific focus only on Medicaid and Medicare, we have designed our entire person-centered approach, all of our operations, infrastructure values and vision to the unique needs of this population. Rather than a commercial plan retrofitted to Medicaid – this is what we do. Today, we operate in many states who were on the forefront of Medicaid managed care including Florida, Arizona and Hawaii who have run Medicaid managed care programs for decades. We understand how to help the program evolve, to provide more accountability and transparency, and to be part of contracts that have achieved a balance of tight controls and measurements while maintaining flexibility and incentives to innovate, which is often seen in more mature programs.

Many of the "next generation" value propositions LDH has put forward in its White Paper are simply part of what we believe is necessary to appropriately care for Medicaid members. Whether it's pioneering a social determinants of health model or leading the industry in high-touch provider engagement, we believe Louisiana's Medicaid recipients deserve the best and most innovative approaches to a Medicaid managed care program that understands what it takes to drive toward better care, better health and lower costs. We thank LDH for the opportunity to provide feedback on some of the core principles of the 2019 procurement, and hope that our experience can help Louisiana continue to evolve Healthy Louisiana to match the state's goals for the program.

Name of individual or organization: WellCare of Louisiana
If an organization, type of organization: Insurer
Region represented by organization: Statewide

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....

WELLCARE RESPONSE

How many plans to place into any Medicaid Managed Care program is one of the most challenging decisions for a state. We have seen states take both approaches with some expanding the number of plans and others shrinking the number – often for very divergent reasons. Some states have expanded plans or built regional opportunities to expand choice and encourage innovation. Others have consolidated and reduced the number of plan hoping to achieve streamlined management for the state agency and efficiency for providers. Given the scope and size of Healthy Louisiana, we caution against reducing plans too much as it could weaken Member access and choice. However, we don't necessarily

offer up a single recommendation for LDH. Instead, we offer the following key questions LDH may wish to consider based on our experience working in a diverse set of states – some with only three plans and some with dozens:

- What is the future of the program and how much revenue does LDH want concentrated among few plans? As Healthy Louisiana has grown with the carve-in of behavioral health and the addition of the Medicaid expansion population, does it make sense to have more plans to absorb the added population and services? As the state may still consider adding other complex populations, could reducing the number of plans too drastically hinder LDH's ability to leverage the best expertise of individual plans related to more complex and waiver populations?
- Louisiana has already experienced plans that were less than successful. Is there a risk to continuity if the number becomes too low and too many members are concentrated in a few plans?
- Do five plans individually have enough buying power to change behavior? Would concentrating buying power have a greater impact? Are there other ways to leverage the impact of the power of the payer rather than reducing member choice – such as requirements for standard provider outcomes and practice transformation activity?
- While certain providers and provider types may struggle with administrative issues related to having 5 plans, we have found some providers become smart at leveraging competition in the plans to develop unique contracting arrangements. This further drives innovation in value-based purchasing and alternative payment models (APMs).

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.

WELLCARE RESPONSE

By focusing on quality outcomes and providing health plans flexibility in how they achieve those outcomes, the most natural state for an effective MCO will be to create efficiency and effectiveness in the system. While we understand LDH's desire to codify in contract standardization across the plans, we encourage you to develop an environment through the procurement process that places a premium on innovation that advances the state goals. In the white paper, LDH states "Preferred MCOs will be willing to engage in and support continuous quality improvement on administrative, clinical, and efficiency metrics." This should be the standard method of doing business for an effective Medicaid managed care program with or without contract requirements. We encourage plans to look at a history of improved quality in potential MCOs. Consistent growth and improvement in administrative, clinical and efficiency metrics clearly demonstrate a plan's ability to be a learning organization – to analyze data and build innovations and interventions that continue to move their programs forward.

ADVANCING EVIDENCE-BASED CARE TO MEET THE TRIPLE AIM

Integrated clinical care with clear clinical practice guidelines based on evidence are critical tools for a health plan to advance evidence-based care among their providers. With or without a state mandate, a Medicaid managed care plan is only truly successful if they can promote behavior change based on the best clinical practice. To ensure MCOs have effective approaches in this area LDH should expect plans to demonstrate a proven track record of provider support and education on evidence-based care and best clinical practices; a value-based approach to incent the highest quality clinical care; a way to help patients get care from the most effective provider groups while maintaining member choice and voice in

the process; a process for engaging providers in determining best clinical practice and a method for evaluating use of evidence-based care and quality outcomes among their providers.

c. **Enhance Network Adequacy and Access Standards**

Request for input: Please offer suggestions for changes in the next Medicaid managed care procurement to enable the Department and its contracted MCOs improve and ensure enrollee ready access to covered services, especially in rural and underserved areas.

- What types of reporting and monitoring of MCO provider networks would you recommend to better assess the adequacy and timeliness of access to care for Medicaid MCO enrollees?
- What specific delivery and care coordination approaches might MCOs employ to meet the needs of enrollees in rural and underserved areas?
- How might the Department improve its evaluation of the adequacy of MCOs' response to enrollee health care needs in rural and underserved areas?
- Are there deficiencies in MCO provider networks in certain regions/parishes and/or covered services that LDH should specifically address in the managed care procurement?

WELLCARE RESPONSE

In many cases, the types of programs need to deliver healthcare in rural areas necessitates the highest level of innovation. WellCare has delivered statewide Managed Care solutions in a variety of states with a similar mix of urban and rural communities like Louisiana. LDH should ask specifically how Managed Care Organizations will solve for access issues in rural areas. The questions should outline the outcomes the state is desiring to achieve in those rural areas without limiting the solutions each organization can bring to bear. This will allow each company to describe specific solutions related to transportation, access to specialists, and community relationships that will help LDH achieve those goals.

Rural parishes will provide the largest challenge for a MCO to achieve traditional network adequacy. LDH should allow for technological or other innovations to allow the MCO to achieve the true goal which is a rural Member's access to a specialist in a timely manner. This may not be achieved through more traditional time/distance standards so flexibility can be provided and then monitored through other means such as surveys and mystery shoppers to confirm the achievement of the standard.

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

Request for input: Please suggest ways in which successful bidders might demonstrate initiatives that would meet the Department's goal to improve enrollee access to primary care, and the Department's desire for increased practice transformation into medical homes.

- How might the Department encourage or require contracted MCOs use of telemedicine or telehealth, and e-visits to improve enrollee access to care?
- How might the Department encourage or require MCOs to adopt effective triage lines or screening systems, or other technology to help improve access and coordination of care?

WELLCARE RESPONSE

Many more states have forwarded medical home concepts through their Medicaid managed care models. We encourage LDH to look at states like Missouri for ideas on how to promote practice transformation through the Medicaid plans. Our Missouri affiliate, for instance, reworked our staffing model to adjust to the state's clear desire to move care coordination closer to the provider level. In Missouri, we developed a unique approach called our Provider Care Advance Team (PCAT) dedicated to helping providers through practice transformation into true medical homes. Potential bidders should have a proven model for practice transformation built into their value-based contracting models. Plans

should offer LDH both specific data to demonstrate success in this area through increases in members assigned to medical homes, improved health outcomes for members in medical homes as well as provide references directly from providers who have received such support. LDH has an opportunity to identify best value among competing health plans by asking for each plan to establish benchmarks and annual goals for growth in medical homes within their network. Those goals can then be placed into contract to ensure adherence. This is a common practice in a state like Florida where plans offer up very specific Service Level Agreements on a number of metrics including access metrics that promote competition and help the state with identification of best value among competing health plans.

ENCOURAGING TELEHEALTH TO IMPROVE ACCESS

We encourage flexibility among plans to prove their ability to improve access through telehealth options and to offer commitments to the state for utilization of these technologies to improve access. In Florida, for instance, we offered the state a unique way to measure telehealth as part of measuring access and availability that we would be happy to share with LDH. By allowing plans to consider telehealth as part of their traditional access and availability standards, they are more incentivized to help providers invest in telehealth and innovate in delivery mechanisms.

TRIAGE LINES OR SCREENING SYSTEMS TO IMPROVE ACCESS AND COORDINATION

Medicaid members often face very specific and unique needs based on population type. We encourage LDH to consider setting differential requirements for plans to screen members based on condition or population type rather than based on the entire population. For instance, we have seen states establish screening benchmarks for a variety of members with special health care needs, such as pregnant women or individuals with HIV. By establishing different benchmarks for screening rates, plans have an opportunity to better target screening tools and innovations to reach difficult to contact members, as well as use of stratification technology to find members with the most complex needs and to offer appropriate and timely interventions. While nurse triage lines and behavioral health crisis lines certainly have a place and should be just standard practice for any MCO, we believe more targeted approaches to screening and outreach for coordination will have a greater impact.

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?

WELLCARE RESPONSE

WellCare chose to integrate behavioral health care within our operations, rather than subcontracting it out, several years ago. From that experience, we have learned that offering an integrated approach to care at the payer and provider levels requires a few critical elements: Experience, infrastructure and innovation. These elements don't appear because they are mandated in contract or because it is desired – it requires dedicated resources and a focused approach to integration. For a plan to promote true integration within itself and among its providers, it must first recognize the challenges of integration and have very specific tactics and plans to address those challenges. In our Florida affiliate, for example, we have held integration summits across the state inviting behavioral and physical health providers to come together to discuss what it will take for them to move to more integrated models. From these lessons along with continued analysis of our own data as the largest plan in the state with a very diverse

population with co-morbid conditions, we continue to adjust our program, contracting models, support tools, investments and infrastructure to help the system break through those barriers. LDH should expect plans to be specific in their approaches and goals around integration with reasonable expectations understanding the unique challenges in Louisiana. It is an opportunity for LDH to differentiate between competing MCOs as they demonstrate specific understanding the of the challenges unique to integration in Louisiana.

It's also important that even as the health care industry promotes integration, we also recognize the need for specialization within an integrated environment. Members with very complex Serious Mental Illnesses, Substance Use, and Severe Emotional Disturbance conditions need plans that have a focused approach on meeting those needs. We encourage LDH to use the RFP to force plans to demonstrate not only their ability and experience in integration, but also their ability with specific results and outcomes in offering specialized care to members with behavioral health needs. A few ideas on how LDH can encourage better behavioral health care:

- Require MCOs to offer a plan to grow behavioral health homes in the state
- Look for plans that offer innovative approaches to shoring up gaps in access to psychiatric care, which is a critical problem across the country
- Ask plans to demonstrate success in key behavioral health metrics, with a specific focus on reducing ER use and institutional or hospital care
- Require plans to demonstrate the ability to pay for value in the behavioral health system
- Ask plans to demonstrate how a hierarchy of needs is deployed within an integrated model to ensure members with primary BH needs receive the right kind of care for them

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.

WELLCARE RESPONSE

Adopting value-based payment methodologies in the Medicaid program requires a unique and targeted approach. Programs that apply in the commercial space or even in Medicare alone don't always translate to larger Medicaid providers or to providers where Medicaid is only a small portion of their patient panel. And it rarely translates beyond primary care and health system provider types. To achieve real value in Medicaid, APMs need to extend to diverse provider types (e.g. behavioral health community providers, skilled nursing and obstetricians, to name a few). As the largest Medicaid Managed Care plan in states like Florida and Kentucky, we have learned that to promote adoption of APMs plans have intense responsibility that includes the following:

- Specific goals and objectives grounded in quality outcomes
- Intense provider support in-person and every step of the way
- Strong data analytics and profile sharing mechanisms to help providers understand their success toward achieving goals
- Meaningful payments and payment structures

PROVIDER READINESS TO PARTICIPATE IN VBP ARRANGEMENTS

We find providers at very different states of readiness to adopt higher levels of risk arrangements with most still only being able to manage Pay for Quality (P4Q) or Shared Savings type programs. This is why readiness assessment is a key element of our approach to VBPs. By establishing a path along the LAN-APM Framework (Learning Action Network-Alternative Payment Methodology) for each individual provider, rather than a one-size fits all approach, we find we are more successful in improving provider readiness to take on more intense models of care. ACOs offer a unique opportunity for health plans to partner with providers and engage them differently. In the Medicaid space, ACOs have been more challenging because of payer mix and other challenges unique to the population, but not impossible. We encourage LDH to allow plans flexibility to build VBP programs that meet needs of individual providers. And we encourage LDH to measure plans on their ability to support providers through the process.

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?

WELLCARE RESPONSE

Health plans who are adept at managing Medicaid members naturally assume a population health approach to care delivery, identifying members at every level of need, stratifying their needs and designing interventions tailored to those needs by population. Health plans should demonstrate success in achieving the state's specific population health goals, again with a focus on continued improvement in key population health metrics.

Key aspects to include in a population health strategy plan would be such items as:

- Defined goals for improved population health on specific categories (e.g. reduce the rate of NICU babies by a certain percent by 2025 or reduce the rate of ER use by children with asthma by a certain percent, etc.)
- Provider engagement in those goals through value-based contracting aligned to population health goals
- A strong approach to Social Determinants of Health recognizing that improving population health means improving member quality of life.

h. **Improve Care Management/Care Coordination at MCO and Provider Levels**

Request for input: Please offer suggestions for the RFP and/or model contract functions and elements related to improving care management and coordination at both the MCO and provider levels. In addition, please provide your opinion on whether MCOs should be required to employ, support, and/or utilize Community Health Workers for certain populations and care management interventions? Please elaborate.

WELLCARE RESPONSE

Key elements to improving care management and coordination that LDH should look for from potential bidders include the following:

- A strong approach to identification and stratification of members designed specifically for Medicaid members. This is critical because traditional models that rely only on costs can mask members with complex problems, particularly those with behavioral health needs.

- Integration that recognizes a hierarchy of needs but provides every member with a care management need an Interdisciplinary Care Team that includes physical, behavioral, pharmacy and social expertise
- Clinical platform technology that is integrated and offers person-centered care planning tools, seamless sharing of data with members, caregivers and providers, and alerts and reporting that helps ensure members follow their care plan and interventions are provided timely.

COMMUNITY HEALTH WORKERS

LDH has an excellent opportunity to differentiate between MCOs based on how they approach care management and care coordination. Rather than requiring a specific model, LDH can rate which plans bring best value to the state through how they approach care management and each MCO should demonstrate the success of its approaches through the use of defined data metrics, such as utilization and HEDIS® metrics for members engaged in care management and care coordination. While some plans exclusively use Community Health Workers (CHWs) to visit members in their homes and have their nurses and/or social workers by telephone only, WellCare uses licensed professionals in our WellCare at Home model where nurses and licensed clinical social workers visit members in their homes. We do use CHWs or other community-based health workers assigned to cases based on a defined hierarchy of need.

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. ...

WELLCARE RESPONSE

WellCare has been a pioneer among Medicaid managed care plans in designing and implementing Social Determinants of Health (SDOH) models, and we would be happy to meet with LDH leadership to share a variety of lessons learned and best practices. Our CommUnity Impact Model was born out of the organic need we saw to appropriately care for Medicaid members originally in our WellCare of Kentucky affiliate. It has since spread across all of our state health plans and is a central tenet of our business. We know that there is no way to achieve the triple aim goals without meeting the social service needs of our members, who often face complex life situations. In brief, CommUnity Impact takes fundamental principles of a Medicaid managed care program and applies them to SDOH. For example, we build access through a network of social service resources, including a directory or database of those services with built-in referral mechanisms. We offer telephonic social service case management through our CommUnity Assistance Line, as well as through an integrated approach to care management and service coordination. We design contracts with social service resources that allow us to track and share member data and use this data to determine best value and support program growth. It also allows us to make smart investments back into our communities based on data, program effectiveness and specific member need rather than simply making investments for "political" reasons. Core to our model is an intensely local approach to CommUnity Advocacy where local staff builds relationships in their individual communities to identify specific community needs rather the building a one-size-fits-all approach. This is particularly important in a state like Louisiana where the needs of members in Central City, New Orleans look very different than the needs of those in the Delta region of the state.

> *"Having an Advocacy Department dedicated to meeting the needs of its community speaks volumes about the company. So often, people walk away from corporations feeling like just another number. However, with WellCare it's more like 'I Matter' as a partner or as a member in the community. WellCare's Advocacy Team has gone*

> *above and beyond the call of duty to support URLinked Charities efforts to bridge the gap with our youth. Moreover, I am most certain that I can count on WellCare for future initiatives with the homeless population, the elderly and disabled."*
>
> ***Iris Thurman, CEO of URLinked Charities***

Since first introducing CommUnity Impact, we have worked with multiple states to help them consider how SDOH models fit into Medicaid programs and their managed care contracts. We offer a few suggestions here, but given the unique nature of this area and the many opportunities it presents LDH, we would love to visit with leadership and explain our recommendations in more detail:

- Develop a set of parameters and requirements that include reporting and performance requirements and incent innovation in this area by placing value for proposals who offer innovation and proof their model works.
- While some states have considered prescribing one specific SDOH model, we encourage LDH to allow plans to innovate and demonstrate best value as a key differentiator in selecting plans.

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.

WELLCARE RESPONSE

As noted previously, LDH has an opportunity as it refreshes the Healthy Louisiana program to take advantage of some of the best practices in Medicaid Managed Care across the country, particularly as it relates to the use of Value Added Benefits (VABs). Value Added Benefits have historically been more about member plan selection than quality outcomes addressing specific needs. At WellCare, we take a very different approach. We see VABs as powerful tools to help us achieve our objectives to improved health outcomes, not just as marketing tools. LDH can encourage best value competition and innovation in this area by placing a premium on VABs in the RFP process. MCOs should not only offer VABs, but should be scored on the value of the VABs offered. LDH can look at the recent procurement in Florida as a good example of leveraging VABs to encourage plans to offer more to members in a competitive environment, including pricing of those VABs to show how much value they bring. Our comments in this area apply to VABs for enrollees.