29 December 2020

Easterseals Louisiana thanks you for the opportunity to provide comments to the Louisiana Department of Health's 2021 Request for Proposals for the Louisiana Medicaid Managed Care Program. This continued commitment to engaging stakeholders in the Program's design is critical. Please find below our recommendations of features to be included in the RFP, model contract, and implementation of Managed Care in Louisiana. We would welcome any further dialogue you would wish to have; please feel free to reach out any time.

Regards,

Matthew Wallace
Vice President Strategic Initiatives and Partnerships
mwallace@laeasterseals.com
225.888.6055

1. **Limit Number of Statewide MCOs and Enforce Accountability**
    a. Each MCO maintains its own sets of regulations, credentialing process, variations in interpretation of medical necessity, prior authorization requirements and processes, and differences in member services and claims processes and procedures. This increases confusion and administrative burden for providers and adds cost. In the behavioral health space, these differences make the program unsustainable for many providers
    b. Reducing the number of MCOs will also reduce the monitoring burden on the Medicaid agency, whose responsibility it is to monitor and regulate the contracts and quality of services provided by their vendors. The contracts must contain defined processes for compliance and penalty provisions for noncompliance should be sufficient to deter intentional behavior. Penalties and sanction must also be enforced.
    c. Reducing the number of MCOs will also reduce overhead costs for the system; fewer high-level staff, CEOs, CMOs, HR efficiencies, etc. In keeping with CMS guidance, Medicaid should limit the number of plans to the minimum number allowable of two.
    d. Multiple health plans with members receiving different services and interventions is counter productive to population health strategies and may negatively impact health outcomes.

e. Regardless of the number of plans, LDH should revive its plan to have a single, central credentialling system to reduce administrative burden on providers.

2. Enhance Network Adequacy and Access Standards

a. Medicaid should continue to require and enforce travel, distance and appointment time requirements for network adequacy standards, regardless of any additional flexibility at the federal level. Network adequacy criteria must include a range of specialty providers including behavioral and mental health providers. Special attention should be paid to behavioral health network adequacy as many clients have reported difficulty in obtaining access to high quality services.

b. Bidders should be required to describe how they will build a network to support the mental health needs of individuals in Louisiana's Home and Community Based Waiver Programs. These individuals often need highly specialized behavioral health supports and finding providers who will see someone with an intellectual or age-related disability is challenging.

c. Vendors must be held accountable by LDH to support and assist beneficiaries in securing timely specialty appointments and services by not only maintaining adequate networks, but ensuring patients have access to the types of services needed and times that they are needed. Vendors should be required to pay above the fee schedule or provide special prior authorization to gain access to providers not normally in network should their traditional network not meet the needs of members needing specialized supports.

d. LDH should continue to financially incentivize behavioral health screenings, such as screenings for substance abuse/addiction (e.g. the SBIRT assessment) across the life course. Expanding these screenings will highlight the need for services in communities and vendors must be required to support providers and members in securing needed referrals and appointments. LDH contract language and expanded guidance must be straightforward and clear as to the vendor's responsibilities, including current contact information on help lines for provider and member assistance and availability of care managers. Quality metrics such as follow-up services for positive screens and developmental screens should be incorporated into the contract or into the monitoring process.

e. Contracts should require/encourage vendors to reimburse services outside or above the current fee schedule to increase member access to harder to obtain services and impact quality improvement. The state fails to reap the benefits of a risk shifting managed care program if the vendors only reimburse for the same services as a fee for service program. For example, reimbursement for behavioral health screening and intervention to primary care providers could incentivize the provider to increase the length of the appointment time in order to better address behavioral health needs.

f. Provider registry requirements should include subspecialty providers, separated by adult and pediatric, and those with open panels. Vendors must be required to maintain accurate directories. Providers and members rely on this information and low percentages of accuracy render the directories meaningless.
g. Vendors must be required to prioritize Louisiana domiciled health care providers including telemedicine/telehealth providers. Telemedicine/telehealth should be used according to standardized clinical practice guidelines. Adequately reimbursing for telemedicine/telehealth and providing technical assistance and encouraging co-location could also increase integration of behavioral health in primary care, as well as increasing access to subspecialty care.

3. Increasing access to and participation in Care/Case Management

a. At a minimum, the RFP must re-design standards of care and set minimum expectations for care and case management service delivery. The current process and implementation elicits very low member participation in case management with the vendors, as evidenced by the self-reported managed care data.
b. Medicaid should require vendors to stratify members based on their care management needs. As members require more intense levels of care management, vendors should be required to offer that care at the highest level of evidenced based intervention available and be encouraged to contract with established community providers, physicians and hospitals to move the care closest to the patient and the local system. Reimbursement for these services should be at a rate to encourage high quality providers to enter the marketplace.
c. 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 must be encouraged to increase data sharing, decreasing duplication, and improving outcomes. Vendors may not always be the best entity to be the “hub” of a member's care coordination; vendors should be required to contract with other entities such as community or health care providers to achieve delineated outcomes. The current model for care management delivery is not effective. In many cases, providers or community case managers are scheduling appointments, securing DME, providing case management between appointments, and advocating for clients to the MCO care and case managers. Many different provider types are better positioned to provide care management to patients than the managed care plan.
d. Care management needs include not only clinical needs, but also social supports to address the social determinants of health and must be offered in an equitable manner. Since the introduction of managed care, providers have not been reimbursed for Targeted Case Management, although many behavioral health and social support providers such as

home visiting and nurse navigation, offer these traditional social services interventions to help members navigate complex systems. Contracts should be structured to allow for reimbursement of these services at the provider level.

e. Vendors should be required to describe their strategies for care/case management and identify the type of staff executing these functions. In their response, bidders should describe why it is the right intervention with the right provider type for the member (MD, PA, NP, RN, LPN, Community Health Worker, or paraprofessional).
f. The RFP should require bidders 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. Vendors 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 services. Vendors should clearly outline a process for providers to assist members in accessing care/case management including working phone numbers and current email address.
g. To improve the effectiveness of triage lines, vendors should have specific deliverables that are regularly monitored and audited for clinical effectiveness, customer service, and utilization.
h. Care management and other member coordination services offered by vendors should include much clearer assistance with coordinating transportation services to help ease the burden on patients to navigate these barriers to care.

4. Improve Behavioral Health Services for Members

a. The current structure of the Louisiana Medicaid Managed Care Program does not promote organizations to offer behavioral health services. The limited approved interventions on the fee schedule, provider requirements, and burdens from the MCOs make group practices unsustainable. For groups to carry the burden of benefits and overhead, reimbursement rates for services such as CPST and PSR must be increased.
b. Before many members can be successful with interventions such as CPST and PSR, they must meet their basic needs such as shelter, medical, nutrition, and employment. Bidders should describe how they plan through their own case management or via contract they plan to help members meet these basic needs.
c. LDH should continue to innovate and require MCOs to offer evidenced based interventions such as PEER Support to members. These services should be available to be provided not only by LGEs but community-based providers.
d. To increase program quality, LDH should require Vendors to contract with community-based nonprofits to offer behavioral health supports. There are many advantages to members having access to organizations vs. individual behavioral health providers. When organizations provide the

support they often are able to link members to wraparound services within the agency. A premium should also be placed on incentivizing organizations to integrate physical and behavioral health services into one location (i.e. co-location), to reduce member abrasion pertaining to having to deal with a care system that is still too fragmented and cumbersome to navigate.

e. Bidders should be required to describe how they will better coordinate and contract with the state's 10 LGEs and their contractors to offer behavioral health supports to their shared clients.

5. Promote Population Health and Quality Improvement

a. Vendors should be required to apply agreed upon, consistent clinical pathways utilizing nationally recognized clinical practice guidelines, i.e. a standard approach to common diseases and treatments.
b. The vendors should be required to promote and refer to population health evidence-based programs, utilizing a common definition and standards, including monitoring, evaluation, and CQI. The RFP should require a description of their strategies and goals and be shared amongst contractors to generate economies of scale. Medicaid should require bidders to discuss the level of evidence (emerging, promising, or best) of proposed programs and interventions they plan to offer members and include information on whether these programs are developed internally or offered by a national provider organization.
c. Medicaid should align quality measures, as well as value based purchasing initiatives 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.
d. To better maximize state tax dollars and leverage existing resources, vendors should be required to invest in state supported programs and services 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..
e. Medicaid should continue to include behavioral health quality metrics as contractual performance measures, but also require vendors to report on more robust programs and specific efforts associated with outcomes.
f. Vendors should be required to stratify and report data by race and ethnicity and other factors such as age and location for internal quality improvement to determine disparities in order to improve outreach and outcomes to enrollees. Vendors should also be required to report on those quality improvement efforts.

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

a. Bidders must show a commitment and have concrete plans in their response to the RFP to embed an equity focus to their internal work. Bidders must demonstrate processes to engage beneficiaries and

community members in key decision/planning points to ensure that strategies and programs are culturally competent and meet the needs of members. Vendors should train their staff on how to effectively and respectfully engage communities, and/or hire community/family representatives (parent liaisons, etc.)

b. Vendor data should be collected and stratified based upon health equity and social determinants of health factors and accuracy of the self reported data could be tied to the quality withhold using verification sampling.
c. Vendors should be required to 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. Medicaid should encourage vendors to contract with community providers who support patient's behavioral health outside a traditional clinic setting.
d. Bidders should propose and implement innovative solutions to issues related to the social determinants of health such as substandard housing, transportation, food insecurity, and community violence.
e. LDH should include the 90 day health assessment from the last RFP in this RFP and have Bidders describe how they plan to engage members in completing this survey, if they plan to contract out this survey administration, and how they plan to address member needs based upon their response to the survey

7. Apply Insights from Behavioral Economics to Facilitate Enrollees' Healthy Behaviors and Choices and Support with Value Added Benefits

a. Medicaid should provide a list of initiatives from other relevant state agencies such as OPH, OBH, LGEs, DCFS and Workforce Development that could be supported by additional resources through value added benefit programs. Consider which other services members access and how could they be tied to behavioral economic incentives to improve patient compliance; bus passes, child care, "slots" in services, additional dollars loaded on SNAP cards, etc.
b. Vendor value added benefits should 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.
c. Vendors should be required contract with providers to financially incentivize maintaining members at lower levels of care, and reward providers for successfully diverting unnecessary hospitalizations, assuring medication compliance, reducing/eliminating episodes of homelessness, etc.