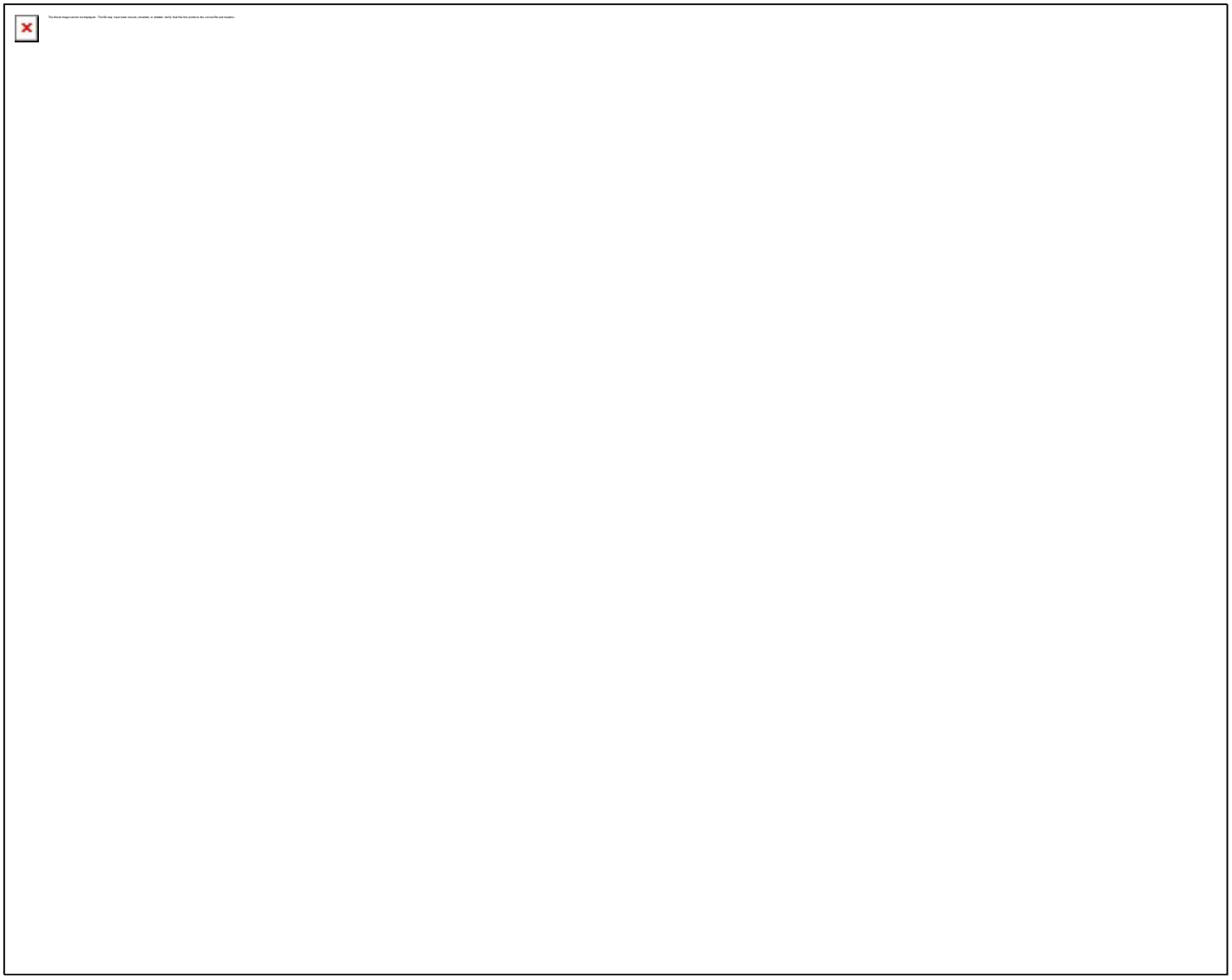
Bradley Wellons

From: MCO3.0Feedback@la.gov
Sent: Wednesday, December 23, 2020 11:17 AM
To: MCO3.0Feedback
Subject: 2021 MCO RFP Online feedback submission notification

The Louisiana Department of Health (LDH) plans to release a Request for Proposals in Spring of 2021 for its Medicaid managed care contracts. You are invited to provide feedback on the areas of interest listed below. You may comment on one or all areas of interest. All comments will become public record and may be published at some point in the future.

Name of Individual or Organization	Tony Mollica on behalf of Humana Health Benefit Plan of Louisiana, Inc.
Email Address or Phone Number	amollica@humana.com
Organization Type	Insurer
Other (please describe)	
Is your organization statewide or regional?	Statewide
What regions does your organization represent based on the map below?	



Areas of Interest:

In developing the RFP, LDH has identified the following areas of interest that warrant further research and potential development:

- Behavioral health integration
- Child and maternal health outcome improvement
- Delivery system reform, Disaster planning and recovery
- Department of Justice settlement agreement requirements
- Fraud, waste, and abuse initiatives
- Health equity
- Increased MCO accountability

You may offer your input on these areas in the next section.

Instructions: Please offer input on any of the following areas of interest. You may provide input in as many areas as you wish, but you do not have to provide input on all of them for your feedback to be submitted.

Behavioral health integration - Louisiana Medicaid seeks to integrate financing models by contracting with MCOs that manage all physical and behavioral health services for Medicaid enrollees to decrease fragmentation of care, improve health outcomes, and reduce costs. Goals of integration include enhancing provider access to data, incentives, and tools to deliver integrated services and coordinate care across settings.

Please offer suggestions on how the MCOs can support key aspects of behavioral health and physical health integration and how they can improve integration of behavioral health and physical health care delivery for enrollees in this upcoming procurement. What specific network

development, care delivery, and care coordination services approaches should LDH consider to allow the MCOs to better meet enrollees' behavioral health needs?	
	The National Council on Behavioral Health's recently released report, The Transition of Behavioral Health Services Into Comprehensive Medicaid Managed Care, addresses the evolution of integrated services, program goals, lessons learned, and new opportunities that MCOs can use to support state goals for improving their delivery system. MCOs dedicated to integrated care delivery support the key aspects of behavioral and physical health integration. MCOs can leverage their network teams to build better, stronger, integrated networks ensuring adequacy for all enrollees and supplemented by innovative telehealth platforms to close service gaps. This process allows for partnerships that reflect the entire behavioral health continuum and offers unique, value-based purchasing (VBP) models that incentivize integrated care. For example, VBP models that reward PCPs with shared savings for reducing hospitalizations incentivize PCPs to ensure enrollees receive needed behavioral health services. We suggest this model be supported by provider education, administrative best practices, established referral processes, and data analytics. In our experience, guiding providers along the integrated care continuum developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the best framework for this model. Lastly, acknowledging Act 582 in Louisiana, MCOs could extend their integrated approach to those specific behavioral health services providers (BHSP) in the State that provide community psychiatric support and treatment or psychosocial rehabilitation services to Medicaid enrollees. For care delivery and care coordination services that meet enrollees' physical health and behavioral health needs, MCOs can collaborate with their integrated clinical teams to ensure frequent communication and coordination of services between s of the enrollee's Multidisciplinary team (MDT) and social services supports in their community. Through a dedicated care manager, enrollees can receive support to help them address their unique behavioral and physical health needs. MCOs can also apply tools and resources, such as self- directed mobile platforms that assist all enrollees with behavioral and physical health conditions, and not just individuals with the most complex conditions and co-morbidities. MCOs can leverage their data sharing platforms to streamline and centralize enrollee data, including person-centered integrated care plans, assessments, and medical claims information shared with local providers, to reduce fragmentation and promote coordination across those involved in enrollee care. For those enrollees receiving coverage or services through other state programs, such as the Louisiana Coordinated System of Care (CSoC), MCOs could choose qualified staff to participate in the MDT. This individual would attend MDT conferences to ensure an understanding of the enrollee's needs, explain MCO-specific benefits, assist by identifying service gaps, and facilitate referrals. MCO participation could ensure bilateral communication and create alignment between the enrollee's physical and behavioral health needs. Lastly, MCOs can (and often do) work together with local Medicaid departments, such as OBH and the regional Human Services Districts in Louisiana, to help streamline integrated administrative processes through forums with the State to discuss shared strategies and lessons learned. MCOs could support LDH in their efforts to continuously improve integrated service delivery by participating in strategy meetings or other forums with LDH and other MCOs if requested.
Child and maternal health outcome improvement – Louisiana Medicaid provides health insurance for more than half of all pregnancies and more than three-quarters of all children in the State. The aim of the Medicaid managed care program is to improve child and maternal health outcomes. Please offer suggestions on the key aspects of child and maternal health outcome improvement and what strategies could be used to address these aspects. (Some possible topics may include coordination and transition of care, how to increase patient engagement, how to care for special populations for both mothers and children, and suggestions for mitigating trauma and adverse social determinants of health.)	
	Humana supports the Louisiana Health Department's (LDH) public health goal of improving the well-being of mothers, infants, and children. Their well-being determines the health of the next generation of Louisianans and can help predict future public health challenges for families, communities, and Louisiana's healthcare system. We have reviewed Louisiana's Healthy Moms, Healthy Babies Advisory Council Report, 2020. We acknowledge the efforts the state is taking to address the drivers of adverse maternal, infant, and child health outcomes and associated disparities to improve the state's current rates for maternal deaths and severe complications during labor, delivery, and shortly after birth, further addressing the disparity among African American women in Louisiana who are four times more likely to experience a pregnancy-related death than white women. Key Aspects of Child and Maternal Health Outcome Improvement: Maternal, infant, and child health addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of this population. The primary drivers influencing health outcomes include social and economic factors, physical environment, access to adequate physical and behavioral healthcare, and enrollee behaviors. Strategies Used to Address the Aspects Child and Maternal Health Outcome Improvement: The COVID-19 global pandemic highlights the necessity for a population

	health approach to identify and implement strategies across systems to improve health outcomes. Adopting a population health approach helps to address the holistic needs of the child and maternal health population, including at-risk subgroups. We present the following strategies, which are derived from our industry and our own best practices, to increase the number of healthy mothers and thriving babies in Louisiana: Social and Economic Factors: Studies show that social and economic factors are the primary drivers of health outcomes and can shape individuals' health behaviors. Addressing social determinants of health (SDOH) plays a key role in improving health outcomes for vulnerable populations. LDH may want to consider encouraging MCOs to establish partnerships with and facilitate enrollee linkages to community-based organizations and state programs that address SDOH. Supports include economic resources that address food insecurity, poverty, unemployment, transportation, and homelessness, as well as promote access to the Supplemental Nutritional Assistance Program (SNAP) and Women, Infant, and Children (WIC). Other social supports address community and family safety (e.g., intimate partner violence, violent crime, and child victimization, while educational supports often promote early childhood education, reading level, and high school graduation. Physical Environment: Conditions of the enrollees' homes and neighborhoods have great impacts on the opportunity to be healthy. Feeling safe, connected and supported in a community is critical to the well-being of families and children. Environment influences a mother's pre-conception and perinatal health and a child's growth and development, having an impact on a child's physical, cognitive, and social development. Factors with the most impact are housing quality, toxic exposure (water or air), as well as access to transportation and health services. MCOs can use assessment and care coordination activities to address enrollees' unmet health-related environmental needs through specific interventions and/or an environmental safety plan. Access to Adequate Physical and Behavioral Health Care: Access to comprehensive family planning and pre-conception health, as well as access to prenatal care during the first trimester is shown to improve birth outcomes. Early identification of pregnant women, appropriate referrals to care coordination or care management, and proactive transition of care activities promote positive health outcomes for mom and baby. Necessary supports also include enrolling infants into Medicaid and facilitating their completion of early and periodic screening, diagnosis and treatment (EPSDT) activities, including immunizations and identification of youth with special health care needs. Humana supports integrated care for women, infants, and children, including early identification of behavioral health conditions and referrals to specialists to address depression, and referrals to outpatient and residential treatment programs for moms with substance use disorder (SUD) and their child and family. We also support referrals to specialists in addressing trauma and adverse childhood experiences, attention deficit hyperactivity disorder (ADHD), teen suicide, and more. Provider supports include education and support to promote use of evidence-based practices and high-quality and culturally appropriate care, Provider Toolkit, provider training on various topics including health disparities and cultural competency, value-based payment (VBP) arrangements, and use of clinical practice guidelines (CPGs). Enrollee Behaviors: Population health solutions can influence positive health behaviors, increase enrollees' self-management skills, and encourage engagement in preventive care. These solutions include but are not limited to nutrition (including breastfeeding support), physical activity, weight management, and smoking cessation, including smoking during pregnancy and e-vapor product use. Women and teens benefit from reminders to complete all medically necessary preventive health screenings (e.g., mammograms, cervical cancer screening, and STD screening) and encouragement to engage in family planning services. Enrollee incentives, community/enrollee outreach, and provider alignment are effective tools to encourage well-visit checkups. Behavior change strategies reinforced by social media and technology-enabled tools increase the effectiveness of strategies to influence positive health behaviors. According to the March of Dimes, pregnancies starting less than 18 months after a birth are associated with delayed prenatal care and adverse birth outcomes. These outcomes can include preterm births, low birthweights, and neonatal morbidity and are associated with ongoing health problems. Discussions with the enrollee immediately post-delivery can include education on the importance of birth spacing as well as information about contraceptive options and determining which method the enrollee prefers. Ensuring enrollees are connected with their provider for on-going care and contraceptive services promotes continuous engagement.
Delivery system reform – In the last couple of years Louisiana has instituted a number of reforms related to payment models and provider network structures that will improve quality of care for Medicaid managed care enrollees. These reforms include instituting incentives such as Value Based Payments, and other incentives for quality care. Please offer suggestions on the best way to promote adoption of new payment methodologies that reward providers for the value they create as opposed to the fee-for-service methodology that rewards solely on the basis of volume of services.	
	Striking a Thoughtful Balance between Consistency and Flexibility: LDH's plan to establish VBP payment targets and provider types offers an ideal balance of consistency and flexibility. It incentivizes and promotes health plans to invest in VBP in order to meet

	uniform targets, creating consistency among plans. Simultaneously, by not being overly-prescriptive in the models to implement, it allows for flexibility by giving plans the opportunity to innovate, bring new models to market, and customize models to meet providers' specific needs based on their existing capabilities, goals, and patient panel. Our experience implementing the Agency for Health Care Administration's (AHCA) required MMA Physician Incentive Program (MPIP) in Florida demonstrates the effectiveness of this balanced model. Through this implementation, we supported providers to succeed in the program while supporting AHCA to improve the program over time. We applaud LDH for creating a forum for MCOs to work together, in partnership with providers and associations, to share best practices and identify opportunities to align models/components of models across payers in order to promote administrative simplification and encourage provider participation. This alignment could include similar participation requirements, quality and cost metrics, participation requirements for care coordination, health information technology, and data sharing. Expanding the Scope of Value-Based Payment Arrangements: LDH could consider expanding VBP arrangements to include underrepresented primary care providers (PCPs) such as federally qualified health centers (FQHC), rural health centers, and other providers serving rural and underserved areas. LDH may also consider encouraging and promoting new accountable care organizations (ACO) among providers, as ACOs can give providers an opportunity to join together to take on more advanced payment arrangements than they would individually. In addition, expanding VBP to non- PCPs, such as OB/GYNs, behavioral health providers, specialists, and hospitals will create aligned incentives across the healthcare system to deliver high-quality, high-value care. To support these providers, MCOs could consider including maternity care performance-based payments and medication-assisted treatment bundled payments. Enabling Provider Success in Delivering High Quality High Value Care: As LDH expands further into delivery system reform, it is increasingly important to ensure MCOs' provider supports and services are optimizing providers' capabilities to deliver high-quality, high-value care. Ensuring this support will encourage provider participation and success in VBP arrangements. To support MCOs in this endeavor, LDH could establish a practice transformation fund to which both the State and MCOs contribute, allowing MCOs to pool their resources to further support provider practices. These resources can include dedicated quality and practice transformation staff, care management coordination, training, readiness assessments, and data analytics capabilities to provide timely reporting on care gaps, utilization, and performance. It is important to align practice transformation with quality management infrastructure promoting use of transformation metrics to gauge quality of care across the organization. Because of this, LDH may consider requiring MCOs to offer incentives to promote practice transformation, integrated care capacity, after-hours appointments, and telehealth. Collaborating with LDH, Other MCOs, Provider Associations, and Providers: Advancing achievement of better health, better care, and lower costs through VBP is only possible when state agencies, providers, and health plans collaborate. When MCOs work closely with providers to transition their practices, meeting them where they are on the VBP continuum, a greater number of providers are able to participate and ultimately succeed in VBP arrangements. Providers' success in VBP programs depends on thoughtful incentives, consultative guidance, and a focus on quality of care using consistent and comparable metrics and benchmarks. MCOs could accomplish this through collaborative meetings as well as provider advisory committees. In addition to collaborating with providers, we are willing and eager to be a partner with LDH. Regardless of its VBP approach, LDH may want to convene a VBP workgroup, consisting of diverse stakeholders such as MCOs, healthcare administrators, provider associations, providers, and consumer/patient groups, to provide feedback on current and future VBP models and opportunities for plans and providers to partner to optimize provider performance and reduce burden.
Disaster planning and recovery – Disasters are a part of life in Louisiana, 2020 has proven that. Whether disease or weather-related, disasters present a serious risk to Louisiana Medicaid beneficiaries – who may be heavily impacted by public health emergencies such as COVID-19, or by tropical storms and hurricanes. In the event of such disasters, MCOs play a crucial role in meeting the health care needs of Medicaid managed care enrollees. Please offer suggestions as to what barriers to care enrollees and providers encounter during disaster events, and what specific measures can MCOs take in the care planning process to mitigate these barriers.	
	MCOs must be prepared to immediately and effectively respond to disruptions in service delivery. Though the ongoing COVID-19 pandemic has created challenges for the healthcare community, MCOs have quickly enhanced services for their enrollees and providers. Humana believes that upon the onset of a disaster, MCOs play a crucial role in meeting the healthcare needs of Medicaid enrollees, especially in states such as Louisiana, which faces frequent hurricanes and subsequent public health concerns. The catastrophic disaster of Hurricane Katrina has demonstrated the vulnerability of low-income groups in the city of New Orleans. Based on Distribution of Impacts of Natural Disasters across Income Groups: A Case Study of New Orleans, pre-existing

	socioeconomic conditions were not predictors of flood damage, but played an important role in the response and recovery phases with those with the fewest resources and the least mobility experiencing disproportionately adverse outcomes. Having successfully faced the challenges of hurricanes, from Katrina and Irma to the unprecedented 2020 hurricane season, in addition to the ongoing pandemic, Humana understands the barriers enrollees and providers face; these include, but are not limited to: • Loss of enrollee ID cards and subsequent difficulties in obtaining timely services • Interruption of access to transportation and other social services • Loss of permanent housing and lack of access to temporary housing • Lack of access to food • Inadequate understanding of what to do upon a disaster among enrollees and providers • Disruption of call center services • Interruption in services for critical enrollees including dialysis, chemotherapy and our special needs enrollees • Provider concern with claims processing and timely payments • Increased behavioral health enrollee utilization and need for immediate connection to appropriate care and resources • Technology support to provide solutions to accessing care (e.g. telehealth, enrollee, and provider portals, etc.) To mitigate the barriers, Humana supports that MCOs be responsible for maintaining an emergency management plan. This plan should address potential interruption risks to critical business functions and planning for worst-case scenarios which includes all forms of disasters and public health emergencies such as pandemics, tropical storms and hurricanes. As a long- standing national healthcare company, we believe in partnering and collaborating with health departments, family and children services and other social welfare offices, fellow MCOs, and providers to share our best practices to ensure continuity of care for enrollees. This collaborative approach drives solution building for the future to proactively address issues such as contact tracing, personal protective equipment for home care workers, support for essential workers facing income, transportation and child care challenges, and to coordinate health education across Medicaid communities.
DOJ settlement agreement requirements – In 2018, a Federal Department of Justice (DOJ) investigation found that the State of Louisiana (along with several other states) violated the Americans with Disabilities Act (ADA) by housing mentally ill individuals in nursing homes. Subsequently, LDH agreed to review and add services for Medicaid-eligible adults with a serious mental illness (SMI) in community-based settings under terms of an agreement to resolve the investigation. Care and service integration provided by MCOs will play a crucial part in meeting the terms of that agreement and further advancement of outcomes for this population. Please offer suggestions for how care and services specific to the SMI-diagnosed population covered by the agreement could be developed to both avoid nursing facility placement and ensure community integration upon discharge from placement.	
	We have reviewed the agreement between the Louisiana Department of Health (LDH) and the Department of Justice (DOJ) and have provided feedback for how care and services specific to the serious mental illness (SMI)-diagnosed population can be developed to avoid nursing facility placement and ensure community integration. We suggest following the framework included in the agreement by working with the managed care organizations (MCOs) to implement and maintain the services, programs, and activities in Louisiana to ensure compliance with Title II of the Americans with Disabilities Act (ADA). MCOs can support the SMI population by working with LDH, local governing entities (LGEs), the Louisiana Office of Aging and Adult Services (OAAS), the Louisiana Office of Behavioral Health (OBH), and the other MCOs to achieve the goals of the agreement. Coordination of Services, Programs, and Activities: MCOs can support a person-centered model through dedicated care coordination and provider support staff, including trained case managers with relevant SMI-related experience working with pre-established community-based service providers to support enrollees in the appropriate setting and divert unnecessary nursing facility placements. Identifying the Target Population: MCOs can leverage State resources, and internal tools and data to identify enrollees of the target population as defined in the agreement. LDH can make the target population priority list available for all MCOs to review so that newly identified enrollees can be assessed for appropriate placement at an integrated setting and for appropriate community-based services. Diversion and Pre-Admission Screening: MCOs can collaborate with LDH and other entities on the implementation plan for the new diversion system to prevent unnecessary and premature institutionalization. This collaboration could include input on standardized training for all personnel administering PASRR Level I and II screenings and for the Level of Care determination process so that MCOs can uniformly understand how to make appropriate placements in the most integrated care or community setting. Transition and Rapid Reintegration: The MCO's case management staff can work with LDH and local nursing facilities in the State to serve as part of the formal transition team, including MCO case managers, LDH transition coordinators, OOAS transition coordinators, and community- based providers. The MCOs would participate in outreach milestones determined by the implementation plan, post-discharge case management, and in the Transition Support Committee if requested by LDH. Community Support Services: LDH can work with the MCOs to develop supports in the community that typically serve individuals with SMI, such as a dedicated crisis hotline. MCOs can ensure network adequacy coverage is met and coordinate with substance use disorder (SUD) services, Assertive Community Treatment (ACT) services, and Intensive Community Support

	Services (ICSS) with local community-based mental health rehabilitation services. MCOs also typically have experience partnering with local community-based services, such as those providing peer, housing, and tenancy support. Outreach, Inreach, and Provider Education and Training: LDH can work with MCOs to incorporate provider feedback during the outreach process into the diversion system and coordinate the enrollee education process for inreach engagement to inform individuals of their options and community-based services. As provider training is a core function of MCO operations, training and education can help providers obtain the knowledge to meet the requirements of the agreement. This process includes MCO support for the mandatory training policy and curriculum for initial and ongoing training. Quality Assurance and Continuous Improvement: LDH can work with the MCOs to align quality assurance program improvement plans with the State's quality assurance system to ensure that enrollees receive quality services in a safe, appropriate integrated setting based on their needs. MCOs typically monitor provider performance, incidents, and service gaps to inform the ongoing improvement process and corrective actions. As part of this process, MCOs can provide quality reporting to LDH based on the data element requirements included in the agreement.
Fraud, waste, and abuse initiatives – Program integrity and compliance activities are meant to ensure that taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse (FWA) in Medicaid programs. Prevention, detection, and recovery of FWA ensures resources are efficiently administered in the Medicaid managed care program. FWA initiatives are designed to strengthen the State's Medicaid managed care program integrity and oversight capabilities. Please offer suggestions for changes that could be made in the new MCO contract that will strengthen FWA prevention, detection, and recovery efforts.	
	As a good steward of state and federal Medicaid dollars, Humana acknowledges and supports the Louisiana Department of Health's (LDH) and CMS' endeavors to strengthen Medicaid program integrity through the three pillars of flexibility, accountability, and integrity. Guided by CMS' Program Integrity Strategy, LDH may want to consider the following to strengthen program integrity activities: • Increased commitment to oversight of improper payments through enhanced health department or legislative auditing activities • Utilization of advanced analytics and other innovative solutions to improve Medicaid eligibility and payment data • Cross collaboration with other MCOs and their state partners such as LDH, the Medicaid Fraud Control Unit (MFCU) or other cross border Medicaid agencies to share information about fraud schemes, potentially fraudulent providers, and potential fraudulent activities • Ensuring complete and accurate reporting on payments • Effective data systems to better manage risks. For MCOs with multiple lines of business, aggregating claims data across all lines of business could also identify aberrant provider practices otherwise not flagged by advanced analytic tools Prevention Efforts: Enhanced auditing activities — along with training, education and screening of providers and subcontractors — are central to fraud, waste, and abuse (FWA) prevention efforts. MCOs can work directly with LDH and providers on data analysis of claims information to ensure proper reimbursement occurs the first time. This reduces provider abrasion and enhances FWA prevention efforts. LDH may want to consider, in accordance with CMS' strategy, including these types of enhanced audit and prepayment requirements. Detection Efforts: As fraud schemes evolve, so too, must MCOs' detection efforts. Utilization of advanced analytics and other innovative solutions such as artificial intelligence and natural language processing will be essential to MCOs' successful FWA detection. LDH may want to consider flexibility for MCOs to adjust their detection efforts to respond to and stay ahead of changing FWA schemes, maximizing technological advancements and innovative detection methods. Recovery Efforts: Post-payment recoveries are a significant source of provider abrasion. In accordance with federal policies including the Managed Care regulations (42 C.F.R. Part 438) and Medicaid and CHIP Payment and Access Commission (MACPAC) reports, LDH may want to require timely and complete reporting of payments including coordination of benefits (COB) information, and of potential fraud in order to strengthen FWA recovery efforts.
Health equity – Health Equity is defined as a state where every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Addressing health equity in the context of Medicaid Managed Care means focusing on improving population health by working to reduce identified disparities for Medicaid populations. Quality improvement and health equity approaches will inform and guide managed care in Louisiana. This will include identifying the key social determinants of health (SDOH) and related outcome measures such as baseline health outcome measures and targets for health improvement; measures of population health status and identification of sub-populations within the population; identification of key SDOH outcomes; and strategies for targeted interventions to reduce disparities and inequities. SDOH are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Please offer suggestions for how LDH can require the MCOs to focus on addressing social determinants of health and other health disparities in Louisiana. How can LDH best hold the MCOs accountable for significantly improving health equity among Medicaid managed care enrollees?	

	We are eager to support LDH in its efforts to achieve health equity, and have participated in several public events, presentations, and webinars during which LDH discussed health equity. Here, we offer some ideas about how LDH could require MCOs to focus on SDOH and other health disparities in Louisiana, and how LDH could consider holding MCOs accountable for significant improvements in health equity among Medicaid managed care enrollees. Staff Recruitment, and Training: LDH could consider requiring MCOs recruit specific leadership roles that focus on SDOH and health disparities to integrate their enterprise-wide health equity efforts. This might include leadership roles dedicated to driving health equity-related programs and policies, or collaboration among internal teams and external associates (e.g., Health Equity Advisory Board). In addition, most MCOs use enrollee and community advisory committees, which LDH could consider requiring be comprised of individuals who reflect the geographic, cultural, and demographic characteristics of their membership. LDH could also consider requiring MCOs to recruit staff by networking across local communities, working with universities, community colleges, and community organizations to support their efforts. This strategy would ensure that MCOs build a workforce that reflects their membership's makeup and has the capacity and knowledge to serve their enrollees. LDH could also consider requiring MCOs to offer cultural competency trainings to their employees, including modules on cultural sensitivity and humility, Culturally and Linguistically Appropriate Services (CLAS) standards, and health equity. Data Analysis and Quality Improvement: To hold MCOs accountable for significant improvement in population health and health equity among Medicaid managed care enrollees we support the LDH annual requirement of submitting a population health plan. LDH could continue to require MCOs to collect data on race and ethnicity to inform their clinical model. Several states also require MCOs to address health disparities in their quality improvement initiatives, which Humana supports. LDH could require MCOs to conduct regular analyses of HEDIS® measures by geography, race, ethnicity, language spoken, and gender identity; and could require them to generate reports and dashboards to identify statistically significant racial, ethnic, and geographic differences in health outcomes. This information informs quality initiatives and population and enrollee level interventions to measure the effectiveness of MCO programs and procedures, and to assess networks' ability to match the racial and ethnic makeup of their membership and to meet their enrollees. LDH could also require MCOs to collect and publish data on racial, ethnic, and geographic health disparities within their populations, as well as data on specific conditions and health indicators disaggregated by race, ethnicity, or geographic location. Tracking and trending specific health indicators can inform and encourage projects, programs, and events to improve health equity. Provider Support and Interventions: Recognizing the shortage of providers willing to serve under-resourced communities and the extra costs incurred by those providers who do, some states have adopted programs and more equitable provider payment mechanisms, as Louisiana has done with their Money Follows the Patient program, to encourage providers to serve in these communities and support those who do. States play an important role in developing a culturally competent workforce ready to address health disparities. Providers are MCOs' conduit to delivering culturally competent care and are critical partners on quality initiatives to reduce health disparities. LDH could consider requiring MCOs to ensure that their network development strategies include a focus on achieving and maintaining a diverse provider network. LDH could consider requiring MCOs to provide their network providers with cultural competency training and specialized education and training in response to noted local disparities in specific conditions. LDH could also consider requiring MCOs to monitor access-to- care standards to identify any areas for improvement in the network's ability to meet enrollees' racial, ethnic, and linguistic needs, and to monitor provider behavior through complaints, enrollee surveys, and data analyses to identify and address potential issues contributing to disparities. Another requirement LDH could pursue is for MCOs to share evidence-based best practices around health disparities with providers. Clinical Programs: To require MCOs to focus on social determinants of health (SDOH), LDH could consider health disparities a requirement for MCOs to include in their clinical model, either through their quality initiatives or by ensuring their care management model attends to enrollees' social needs. This could include, for example, requiring MCOs to include SDOH in their initial health assessment and in the predictive models used to determine enrollee risk levels and corresponding interventions. Additionally, LDH could consider encouraging MCOs to design clinical interventions that will increase the reach and impact of clinical interventions through culturally competent messaging to enrollees and considers the cultural uniqueness of the demographic groups that are not most prevalent (e.g. atypically abled, LGBTQ+, BIPOC, LEP), who often experience the greatest systemic and health barriers that contribute to disparate outcomes. Addressing SDOH: LDH could consider continuing to require MCOs to capture data about enrollees' unmet social needs (e.g., transportation, food, housing, employment) through health risk assessments. This information can inform connections with community resources to address these needs. In addition to linking enrollees to community resources, LDH could consider looking for MCOs to implement interventions targeting the complex social needs that contribute to health disparities. LDH could also consider requiring MCOs to collaborate with community organizations, providers, and state and local programs, whether through

	direct funding, referrals, shared staffing, or other mechanisms. Access to Care: Health disparities often result from inadequate access to care, whether due to long travel times or a shortage of providers who can provide culturally competent and linguistically appropriate care. LDH could consider emphasizing to MCOs the importance of solving these issues, and supporting their efforts to do so. This might include MCO efforts to ensure network diversity to reflect their membership, offering telehealth solutions to expand access to rural and underserved communities. Cultural and Linguistic Considerations: LDH could consider continuing to require MCOs to promote CLAS standards. MCOs frequently apply their own processes to deliver services that accommodate the linguistic and cultural preferences of their membership. These can include hiring bilingual enrollee services and care coordination staff, employing a Health Literacy Advocate to inform organization-wide efforts, including language as a factor in the primary care provider (PCP) auto-assignment, and engaging enrollee and community advisory boards to review materials. LDH could also consider requiring MCOs to coordinate with OCPHE, and to collaborate with LDH in a workgroup to address health disparities. For example, requiring the workgroup to work together to disaggregate at least one performance measure by race/ethnicity and implement, fund, and evaluate an intervention to reduce that disparity. The workgroup could also submit a quarterly progress report to LDH documenting their efforts. These workgroups could have a real impact on Louisiana's health disparities by aligning LDH and MCO goals using a coherent approach.
Increased MCO accountability – The MCO contracts specify the MCOs' responsibilities with respect to the Medicaid managed care program. Holding the MCOs accountable for meeting the terms of the MCO contracts are important to the efficient operation of the Medicaid managed care program and ensure quality care is delivered to Medicaid managed care enrollees. While penalty provisions such as significant fines are included in the existing MCO contracts, LDH is interested in enhancing MCO accountability. Please offer suggestions for how can LDH hold the MCOs accountable for statewide policy, operational, and financial priorities in the MCO contract.	
	As the overarching convener of enrollees, network providers, and agencies, managed care organizations (MCO) sit at the intersection of the healthcare delivery system. To enhance accountability for statewide policy, operational, and financial priorities in the MCO contract, LDH may consider implementing the following: Develop a Comprehensive MCO Performance Incentive Program that Promotes and Rewards Accountability: Humana applauds LDH's efforts to improve enrollee health as evidenced by its 2019 EQRO report where the statewide rate met the target rate for 12 of 15 incentivized HEDIS measures. To encourage MCOs to prioritize state goals beyond the realm of quality performance, LDH could consider implementing a comprehensive MCO performance incentive program that includes performance-based incentives related to statewide policy, and operational and financial priorities in the MCO contract. By incentivizing MCO accountability from a comprehensive lens, MCOs are encouraged to dedicate substantial resources and coordinate activities among key stakeholders, including network providers, to achieve state- specific goals and advance LDH's policy areas of interest. Align Reporting Requirements with LDH Goals and Policy Areas of Interest: To enhance LDH's current quarterly report submissions and annual performance evaluations, LDH could adopt industry standard measure sets and align future reporting requirements with state priorities, such as policy areas of interest outlined in LDH's 2018 MCO RFP White Paper Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care. By expanding reporting requirements, LDH will foster mutual alignment with MCOs while ensuring all key contractual components are measured. Facilitate Cross-Collaboration Among MCOs to Optimize Reporting: The future of the healthcare delivery system necessitates cross-collaboration among MCOs. Humana applauds the collaborative culture fostered by LDH as seen by monthly meetings with CEOs and quarterly business reviews. To enhance MCO accountability and LDH's collaborative culture, LDH could consider creating a reporting workgroup to ensure reporting is easily understandable, transparent, and actionable. To enable this, LDH and MCOs could work collaboratively to form a workgroup or other forum to revise the current reporting package; add improved reports; and determine whether there are dashboards that could better inform LDH's analysis, monitoring, and oversight of the MCOs. Coordinating collaboration around reporting requirements will allow LDH to better understand the data the MCOs collect, how the data can be optimized to ensure accountability, and allow LDH staff to identify the gaps in what they collect and would like to collect.
Have feedback on an area not represented above? Please provide it below.	
	Thank you for the opportunity to submit feedback.