Thank 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. Due to the short timeframe, these are unofficial recommendations from the members of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality. The Commission has not yet had the opportunity to vote on these recommendations, but will do so at our meeting on January 21, 2021. We encourage you to consider our comments as they relate to improving health outcomes for Louisiana citizens. Do not hesitate to reach out to Karis Schoellmann (karis.schoellmann@la.gov) who is the lead staff member providing support to the Commission should you have any questions or request any additional information.

1. **Limit the Number of Statewide MCOs and Enforce Accountability**
    a. Each MCO maintains its own sets of regulations, variations in interpretation of medical necessity, variations in prior authorization requirements, variations in member services and variations in claims processing, which in turn increases confusion and administrative burden for providers and adds cost.
    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. MCOs offer varying reimbursement rates to providers which may incentivize certain providers to care for Medicaid beneficiaries, but deter them from seeing patients covered by other health plans with less favorable reimbursement rates.
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. For example, integrating mental health providers who offer community-based services for pregnant and postpartum women and families into networks.
    b. 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. For example, Medication Assisted Treatment should be available and

accessible during pregnancy. Transportation assistance must also be available, especially for patients who need higher levels of care. These services should not only appear available in directories, but have actual availability for patients in reasonable timeframes.

c. We applaud LDH's commitment to financially incentivizing perinatal depression screenings and developmental disability and autism screenings in children. Expanding these screenings will highlight the need for services in communities and vendors must be required to support providers and beneficiaries 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 perinatal depression screens and developmental screens should be incorporated into the contract or into the monitoring process.
d. Contracts should require/encourage vendors to reimburse services outside or above the current fee schedule to increase member access to harder to obtain services that are particularly critical to achieving improved outcomes. 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.
e. As providers expand the use of evidence-based tools to screen for a host of needed supports, vendors must be accountable to assist providers and members in obtaining those services and supports. For example, as obstetric care providers are encouraged to use a standardized tool to screen for Intimate Partner Violence (IPV), and to recognize the warning signs of IPV, reimbursement for the screenings, referral systems and training opportunities should be available.
f. Provider registry requirements should include subspecialty providers, separated by adult and pediatric, and those with open panels. Specifically, for mental health providers serving the 0-5 populations, please require further disaggregation for the youngest ages. 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 sub specialty care, such as neonatology or maternal fetal medicine.

h. The contract must delineate the vendors' obligation to provide for interpreters, including American Sign Language interpreters and tactile interpreters for members who are DeafBlind. Vendors must financially support providers for providing interpreters for their patients. The type of interpreter must be flexible and meet the patient's needs to maximize understanding and patient decision-making.

3. **Increase 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 beneficiary 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.
    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 are scheduling appointments, securing DME, providing case management between appointments, and advocating for clients to the MCO care and case managers. The reimbursement structure for these services should account for the resources being utilized at the provider level. 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. For example, maternal care coordination requires multiple providers to communicate about a patient's care, and ensures patients are linked to non-medical resources such as supports for housing, education,

and economic stability to assist in the reduction of preventable maternal deaths and morbidity.

e. The contract should require vendors to pilot a range of care management models with providers. For example, the Direct Primary Care model.
f. 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).
g. 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.
h. 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.
i. 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. 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. Vendors must also provide coverage for the evidence based medicine recommendations for testing and treatment without undue barriers for patients and providers.
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. Programs such as Nurse-Family Partnership, Parents as Teachers, and Healthy Start.
e. Vendors should be encouraged to invest in state supported systems such as Pregnancy-Associated Mortality Review (PAMR) and Fetal Infant Mortality Review (FIMR) that provide data analysis and quality improvement recommendations for services to their beneficiaries.
f. Medicaid should continue to include maternal health quality metrics as contractual performance measures, but also require vendors to report on more robust programs and specific efforts associated with outcomes. For example, postpartum care for members with hypertension or who have required cardiovascular consultations should be ensured referrals to primary care and case management for up to one year postpartum and access to a full range of contraceptive options and how to access them should also include counseling that has been informed by an assessment of an individual's risk of pregnancy complications due to chronic disease or when pregnancy is contraindicated.
g. Vendors should be required to stratify and report data by race and ethnicity 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.

5. 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, including home visiting programs and infant mental health specialists.

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.

6. **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, DCFS and Workforce Development that could be supported by additional resources through value added benefit programs. For example, breast pumps to support breast-feeding, cribs to support safe sleep, job search assistance to support employment, etc. 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. For example, having a safe infant sleeping environment reduces infant mortality, so if someone is pregnant and goes to prenatal care, vendors can become partners with Cribs for Kids to offer pack-and-plays, car seats, or a stroller to the parent as an incentive for another part of pregnancy care that can also reduce cost, such as adequate prenatal care.