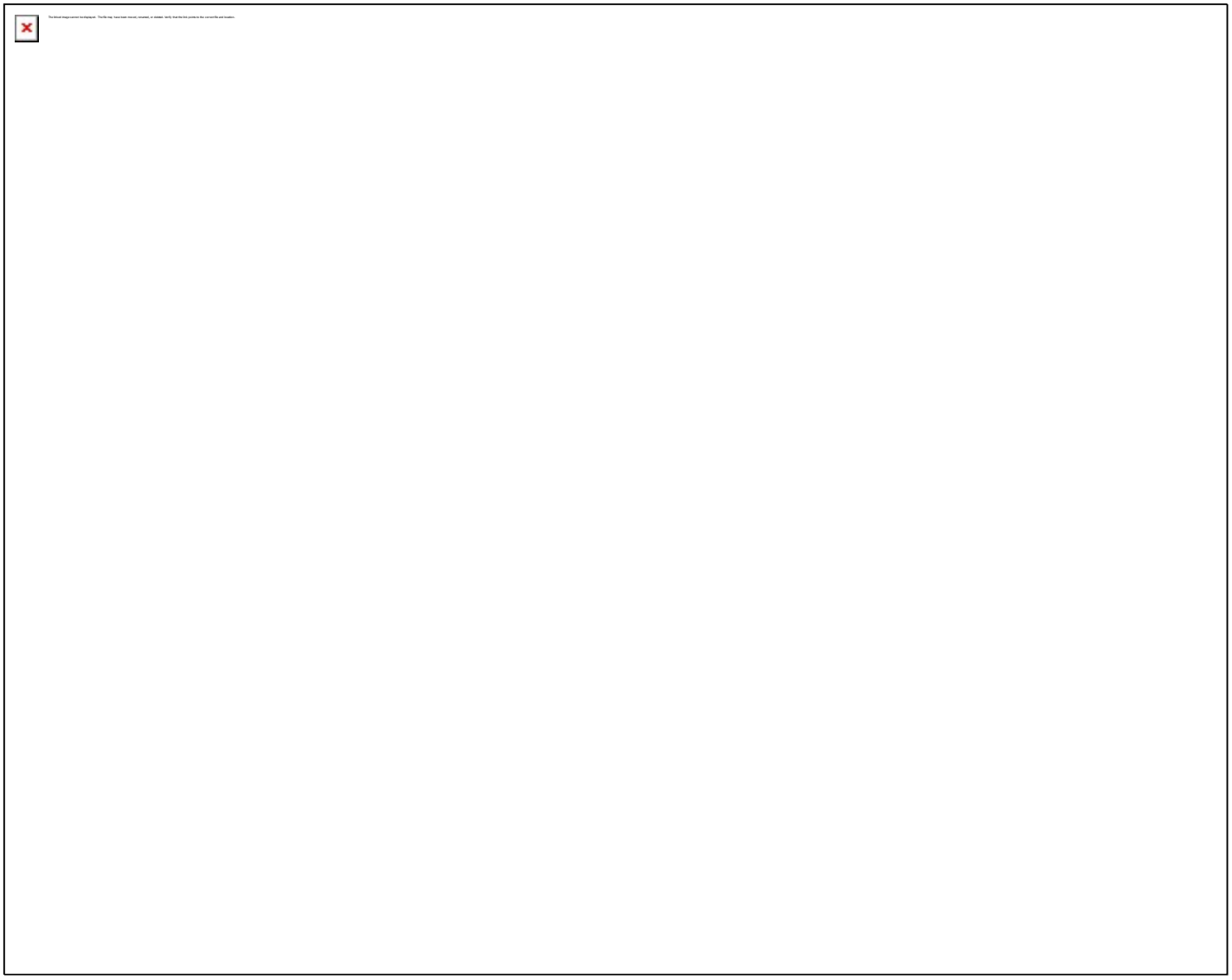
Bradley Wellons

From: MCO3.0Feedback@la.gov
Sent: Monday, December 28, 2020 5:06 PM
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	Louisiana Partnership for Children and Families
Email Address or Phone Number	exec@louisianapartnership.org
Organization Type	Other
Other (please describe)	Child Health Advocacy Organization
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 state should set clear priorities and expectations for MCOs around maternal and child health, especially with regard to pediatric benefit requirements under Medicaid Early, Periodic Screening Diagnostic and Treatment (EPSDT). Ensure the RFP includes a specific section on expectations with regard to EPSDT - screenings as well as any resulting treatment. Examples include prioritizing and incentivizing developmental and maternal depression screenings during pediatric well-child visits; ensuring access to needed maternal, infant, and early childhood mental health; and requiring pediatric quality improvement plans. Data reporting requirements should also be clearly detailed for plans and providers. Remove any diagnosis requirement as a prerequisite for mental health care, especially for young children. Uniformly recognize, reimburse and require use of age-appropriate mental health diagnostic criteria and tools for young children (DC:0-5). Ensure plans support the ability to host multiple assessment/treatment opportunities to observe parent/child interactions before any diagnosis. Questions for plans: 1) How will plans identify and effectively treat mental health needs of pregnant and postpartum women as soon as possible to ensure optimal maternal and child health? 2) How will plans ensure billing and coding requirements do not inhibit access to needed services (e.g. allowing for same-day physical and mental health services when needed)? Improved data transparency and timeliness to track trends: 1) Require reporting of all child and adult core set measures by race, ethnicity, gender, and other demographics. Establish pediatric or maternal health performance improvements plans for failure to meet specified benchmarks. The state should consider additional withholds based on performance. For example, require the MCOs to report monthly screening and treatment performance, enforced by a withhold of a percentage of monthly capitation payments for child enrollees until the month's reporting is received; 2) Require each MCO to designate an EPSDT compliance officer, reporting directly to the CEO, to ensure compliance with EPSDT requirements; and 3) Require the state External Quality Review Organization (EQRO), on an annual basis, to validate the EPSDT data reported and to analyze utilization of EPSDT services by race and ethnicity. Improved developmental screenings: 1) Require plans and their providers to adopt and report on the Child Core Set developmental screening measure (DEV-CH), with billing codes clarified to ensure accurate measurement reporting using claims data. Require or recommend providers use of a validated developmental screening tool as specified in the Louisiana Developmental Screening Guidelines; and 2) Require a minimum proportion of spending on pediatric care. For example, Massachusetts stakeholders recently recommended that minimum expenditures in pediatric care in ACO/MCO contracts should reflect no less than 60% of spending on the proportion of the plan's population through age 21 (e.g., an ACO with 35% of its total enrollment pediatric will invest at least 21% of total dollars in pediatric care. Improved referrals and treatment/promotion of high-performing medical homes: 1) Adopt/assign billing codes for developmental specialist in pediatric primary care (can be done without fee schedule); 2) Encourage/pay for use of staff in the pediatric primary care/medical home to provide/augment developmental services and supports (e.g. CSHCN coordinators/ specialists, Healthy Steps specialists); and 3) Specify providers and models approved by LDH. Managed care plans should encourage the use of dyadic care models in primary care settings as a standard of care through trainings and incentives, including value-based purchasing arrangements Dyadic treatment is a form of therapy in which the infant or young child and caregiver are treated together. A clinician is present with the caregiver-child dyad, or in a nearby room, and coaches the caregiver to encourage positive interactions that can help improve parenting, the parent-child relationship, and the child's behavior. Both the caregiver and child have the chance to experience more positive ways to interact with each other. There are several evidence-based models of dyadic treatment (e.g., HealthySteps, DULCE, Parent-Child Interaction Treatment and Child-Parent Psychotherapy). In this integrated care model, pediatric mental health professionals are available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to offsite behavioral health services. Furthermore, in this model, health care for the child is delivered in the context of the caregiver and family (i.e. "dyadic health care services") so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to make sure they received the services.
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.)	

	MCOs should clearly demonstrate their commitment to child health and development. For example, plans should be graded on the specific ways they promote strong pediatric primary and preventive care. This includes recognition of the importance of parents and caregivers in children's health and the social and economic factors that factor into the overall health of family, most notably racism and poverty. The state should set clear priorities and expectations for MCOs around maternal and child health, especially with regard to pediatric benefit requirements under Medicaid Early, Periodic Screening Diagnostic and Treatment (EPSDT). Ensure the RFP includes a specific section on expectations with regard to EPSDT - screenings as well as any resulting treatment. Examples include prioritizing and incentivizing developmental and maternal depression screenings during pediatric well-child visits; ensuring access to needed maternal, infant, and early childhood mental health; and requiring pediatric quality improvement plans. Data reporting requirements should also be clearly detailed for plans and providers. Require plans to enter memorandums of agreement or subcontracts – that include agreed upon screening and referral protocols - with community partnerships, including but not limited to, family resource centers, child care centers, schools/LEAs, cultural organizations, churches, faith-based organizations, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics. Contracts should provide a 4.25% performance incentive bonus for plans that demonstrate they exceed quality standards on key pediatric metrics of quality. An incentive bonus for pediatric primary care is important, given the documented low rates of children accessing preventive health care, and the long-term benefits of preventive health care to the children themselves as they grow, but also to society and government systems at large. We encourage the Department to consider models that have been successful in other states; currently, half of states nationally use a quality incentive payment/performance bonus structure. Contracts should support the use of community health workers, doulas, and/or promotoras, to educate, support, and engage Medicaid beneficiaries and their families by making their services billable. Contracts should reaffirm Louisiana's requirement for contractors to implement a Perinatal Case Management Program for "reproductive aged women with a history of prior poor birth outcomes and high risk pregnant women." Suggested Contract Language: Add a level of assistance to all "referrals", such as for WIC - Contractor, as part of its risk assessment of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and assist and document the referral of and assistance for pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c). Comprehensive Perinatal Services Program assessments for nutritional, health education, and psychosocial services, including social determinants of health, at initial visit, each following trimester and the postpartum period, with an Individualized Care Plan for identified needs, and documentation in the medical record of services offered, provided or coordinated with referral entity. Contractor shall ensure that pregnant members at high risk of a poor pregnancy outcome or who need mental health or dental services as determined by assessments, screenings, or patient request are referred to appropriate Specialists including perinatologists, mental health professionals and dentists, and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services and appropriate freestanding birth centers are available for those members who wish one. The contractor shall cover evidence based perinatal care models, including care provided via group prenatal care, birth support workers including doulas, midwives, community health workers or promotoras. Deemed newborns: Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. Thereafter, capitation shall be paid to the health plan chosen by the infant's parent or guardian via the enrollment process.
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.	
	Financing for pediatric care services must reflect value over the long term. To be successful, investments in child health services must be viewed as long-term investments, with savings realized beyond the healthcare sector. To ensure children are seen as a priority in both words and actions, the RFP and contracts should reflect this reality through a minimum expenditure requirement for pediatric care. Otherwise, profit motives can translate to short-sighted cuts in preventive care that could dramatically increase public spending in later years. Prioritize children in any payment or delivery system reform efforts, do not apply an acute care/disease management adult approach to children's developmental needs. Incorporate clear prevention services as part of pediatric benefit. Establish a plan and process for ongoing feedback from and engagement of parents,

	families, pediatric care specialists, and other stakeholders with expertise and lived experience supporting children and their families.
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 should be required to work with telecommunications providers (AT&T, Verizon, etc.) to set up telehealth booths that can be deployed to disaster areas so that people can have connectivity with providers in a safe and secure environment. There should be some sort of incentive for MCOs who can maintain connectivity for enrollees who are displaced by storms or impacted by Covid-19-type events which can limit access to care. Telehealth should not be limited to places with good internet connectivity, there should be an active effort to help enrollees overcome internet limitations in their local areas. Questions for plans: How do you ensure providers receive adequate training and support to ensure trauma-informed care? In what ways do you engage with schools, child care centers, and other community-based organizations serving families in their homes and 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.	
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.	
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?	
	Maternal and child health, especially, should be rooted in a broader, sustained commitment to achieve health equity. This starts with more timely and accurate data reporting and a commitment to help communities lead work toward better solutions. Report maternal and child health data by race, ethnicity, gender. Use data to identify gaps in outcomes, access to care. Require or recommend performance improvement activities based on identified gaps, such as maternal morbidity. Use data to find, encourage, and promote community-based solutions, driven by community-based organizations and leaders. Use the range of community health workers and other peer supports to engage plan members that may distrust the traditional health care system. Questions for plans: What is the plan doing to help build a pipeline of providers who adequately represent the race, ethnicity, gender of communities served? How will the state and plans identify and use trusted peers and other community members (e.g. community health workers, doulas, promotoras, etc.) to educate, support, and engage Medicaid beneficiaries and their families, especially young children? Suggested Contract Language: MCOs should be

	required to specifically address how they plan to reduce infant mortality rates among Black infants and perinatal morbidity and mortality among Black women and women of other ethnic minorities with high rates of morbidity. Plans should be required to identify high risk or potential high-risk pregnancies with a particular focus on women of color, which may include doula services, home visiting, case management at OB/GYN offices, or other culturally-relevant services that lead to improved outcomes. Infant mortality rates among Black infants should be included in quality improvement plans. LDH should look to Wisconsin and Virginia for examples of Medicaid managed care programs to improve health disparities among vulnerable pregnant women. Wisconsin focuses on Black women's health disparities, requiring each health maintenance organization to maintain an Obstetric Medical Home for High-Risk Pregnancy, defining high-risk as being Black, homeless, less than 18 years of age, and/or having a behavioral health condition or chronic medical condition. Women enrolled in the OB Medical Home receive enhanced case management through pregnancy to improve birth outcomes.
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.	
	Continue to monitor and report each plan's medical loss ratios (MLR) as soon as able. Monitor per member per month rates against services provided each month, consider working with MCOs to reinvest funds into outreach, quality improvement or other key areas as needed.
Have feedback on an area not represented above? Please provide it below.	
	The aim of the new contracts should be to eliminate silos as much as possible. Children's health cannot be separated from the health of mothers, beginning before conception. Mental health and inter-generational trauma cannot be ignored as it is a core social determinant of health. Community solutions should be sought and utilized whenever possible. None of these contracts should exist in a vacuum, but should be tied into all of the other departments at LDH including Behavioral Health, Bureau of Family Health (including looking at the Risk and Reach Report as well as the Injury Prevention State Action Plan, and looking beyond their work to programs that have worked well in the past, including Home Visiting, LaPEN (Louisiana Parent Education Network) , and comprehensive infant and early childhood mental health. None of these pieces can function alone and the goal of the MCO contracts should be to tie all of the health initiatives of the department to plans and desired outcomes that already reflect community input and evidence-based practice.