## Bradley Wellons

**From:** MCO3.0Feedback@la.gov
**Sent:** Tuesday, December 29, 2020 2:54 PM
**To:** MCO3.0Feedback
**Subject:** 2021 MCO RFP Online feedback submission notification

**EXTERNAL EMAIL:** Please do not click on links or attachments unless you know the content is safe.

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.

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| Name of Individual or Organization | Unite Us |
| Email Address or Phone Number | eric.beane@uniteus.com |
| Organization Type | Other |
| Other (please describe) | Technology Company |
| 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?

Behavioral health integration has emerged as a leading care delivery model that allows for increased access to needed services and facilitates a whole person care approach. To ensure the success of behavioral health integration, LDH is right to eliminate behavioral health as a carve out and ask that MCOs provide both physical and behavioral health services and build adequate provider networks that can enable an integrated benefits package. In doing so, LDH should carefully consider the types of behavioral health integration models and care and technology enabled solutions that can truly support an integrated care delivery model. One model the LDH can support and encourage is the Collaborative Care Model, which outlines the composition of an integrated care team, how to design an integrated care team, and most importantly how to bill for integrated services that are rendered. However, please note that behavioral health integration can be bi-directional, in that behavioral health can be available on-site or accessed from the primary care setting, and primary care can be available on-site or accessed from a behavioral health setting. The latter is important for individuals living with serious and persistent mental illness, for whom their only interaction is the mental health environment. LDH should ensure that behavioral health providers can bill for allowable E&M codes (or other designated behavioral integration codes) and primary care providers can bill for an allowable set of behavioral health integration codes. Additionally, behavioral health integration should not be limited to the adult population. LDH should encourage pediatric practices to implement an integrated care delivery model. For practices that choose to hire the integrated staff, LDH should ensure their provider verification/credentialing process accommodates for integrated practices. LDH should also consider using the IPAT to assess the level of integration within the MCOs provider networks. LDH should also encourage and reimburse for the screening and referral process. Primary care practices should be incentivized to screen for behavioral health issues using validated screening tools like PHQ-9, PHQ-2, DAST, GAD-7, Edinburgh, ACEs, etc. or through benefits and protocols like SBIRT (Screening, Brief Intervention, Referral to Treatment). Integrated care can ease concerns among primary care providers that they have nowhere to refer individuals who screen positive. In an integrated environment, the primary care practices can refer the patient to the behavioral health consultant on-site or to an in network behavioral health provider. LDH should do their best to set fair reimbursement rates for integration codes as well as general behavioral health services, which will help the MCOs build a robust and adequate network. There should also be parity between tele-mental health and face-to-face visits. LDH should also ensure that tele-mental health remains a standard offering that is no longer subject to geographic or eligible place of service restrictions, and even consider that MCOs be required to offer tele-mental health in their network for conditions appropriate to treat virtually. Lastly, LDH should explore technology-enabled solutions that can further enable behavioral and physical health integration in any care setting, support holistic care coordination inclusive of identifying and addressing unmet social needs, and measure improvement and quality of care provided through the creation of integrated care quality measures. For the most acute members this coordination should be delivered via integrated care managers skilled in behavioral health case management.

**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.)

The Louisiana Department of Health can leverage several strategies to improve child and maternal health outcomes for Medicaid enrollees in the State. First, MCOs should utilize care coordination infrastructure which increases children and mothers' access to health and social care providers based locally. This infrastructure enables crucial cross-sector and agency collaboration and communication, reducing the amount of time it takes for families to get the resources they need. Care coordination platforms and embedded screening tools additionally help address children and mothers' adverse social determinants of health before serious health conditions arise by linking mothers and their families to crucial food, transportation, housing and other supportive services. The LDH should standardize and provide implementation funding for a screening tool that assesses unmet needs as well as the prevalence of adverse childhood experiences. In addition, it is crucial that the LDH utilizes strategies that confront and mitigate glaring racial disparities in maternal and child health and increase patient engagement accordingly. MCOs should be incentivized to leverage novel interventions that address the unique needs of Black and Brown mothers and babies and encouraged to work in collaboration with local public health departments to support place-based advocacy and programming for more equitable

access to care for underserved populations. LDH should also provide guidance for MCOs to work with culturally sensitive community-based organizations and providers that are trusted by marginalized populations, and should consider covering services such as doula care and home births. Lastly, we commend LDH for securing a state plan amendment to extend family planning services to individuals who do not qualify for full Medicaid coverage. We suggest that LDH also consider seeking a waiver from CMS to extend Medicaid's postpartum period so that low-income postpartum women at low income levels can keep their full Medicaid coverage beyond two months postpartum.

**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.

As we push to ensure high quality and affordable care is provided to those who are most vulnerable, delivery system reform will forever be front and center and will push us to continue to iterate on the care delivery model we believe will help us achieve the Triple or Quadruple Aim. In line with the accomplishments LDH has already achieved with regards to delivery system reform, we suggest LDH review their existing value based arrangements with a health equity lens. At the 2020 NAMD Annual Conference, California Medicaid noted that there was not equal access or equal representation among the Medicaid clients enrolled in value based programs. Further, LDH should consider how FQHCs can become enrolled in value based programs despite the PPS reimbursement structure that supports payment for face to face encounters. There are several states that support aligning FQHC reimbursement with value based arrangements and this has been detailed by CHCS, NASHP, and NACHC. LDH should also consider reimbursing CBOs for services rendered to Medicaid clients and allowing CBOs to participate in shared savings. Reimbursement for services delivered by CBOs can also be tracked through products like Unite Us Payments that can support a fee schedule and the processing of "claims" submitted by credentialed and in-network CBOs. Lastly, LDH could also consider introducing pay for performance arrangements with certain behavioral health conditions for which improvement can be measured using a validated tool such as the PHQ-9 and GAD-7. Measuring behavioral health improvement remains a relatively novel concept in the US, but has been supported in the UK and defined by the UKs The National Institute for Health and Care Excellence (NICE).

**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.

It is extremely difficult in the face of a disaster for providers to address new, rapidly changing demands, coordinate care across multiple agencies, efficiently absorb and track influxes of new funding, and – critically – match the right resources to those who need them most. Enrollees often experience long lines and confusion about where to seek services as well as difficulty navigating government and healthcare systems that they are either unfamiliar with or have historically distrusted. Moreover, disaster relief is often considered one of the least cost-effective health activities and cannot be a substitute for preparedness (World Bank, 2006). Before the next disaster, we encourage the Louisiana Department of Health to require MCOs to: - Develop and implement a common SDOH referral platform that brings together government agencies, health plans and hospital systems, and community-based providers to address the social determinants of health and connect health and social care for vulnerable individuals. The referral platform should be embedded in the community such that enrollees can access the referral network via trusted messengers and locations with which they are already familiar. Importantly, the referral system should also be dynamic and flexible enough to accurately reflect providers' capacity and ability to receive client referrals in close to real time. - Pre-identify high risk enrollees through the use of social risk indices and preposition resources as needed; conduct extensive outreach to these enrollees in advance to advise them of resources and benefits as well as pre-identify their preferred resources and community partners. - Set up assistance request forms or centralized intake centers that allow enrollees to self identify needs and be connected with an intake coordinator who can link them to resources. Ideally, assistance request forms can be accessed at home via a mobile device or laptop, at a strategically located kiosk or tablet in the community, or via QR code at, for example, a bus stop. Tools such as this facilitate more equitable access to care services for underserved individuals who may not regularly interact with health care and clinical

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<tr><td></td><td>providers. -Leverage closed loop referral systems like Unite Us Payments to support rapid, efficient tracking and disbursement of new funds and reimbursement for services delivered by CBOs.</td></tr>
<tr><td colspan="2">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.<br><br>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.</td></tr>
<tr><td></td><td>In order to support adults with serious mental illness in home- and community-based settings, it is critical to ensure that social needs are treated at the same priority level as medical needs. Failing to screen for, and address, social determinants of health such as food insecurity and transportation needs can contribute to avoidable nursing home placements. Historically, our health system has prioritized clinical care coordination and done too little to connect health and social care and create a platform for coordinating services that address individual needs in a holistic manner -- regardless of whether the needs are related to health, human, or social services. Specifically, we suggest LHD require MCOs to negotiate protocols with state agencies such as the mental health authority, the child welfare agency and correctional agencies for coordinating treatment planning, discharge and other key aspects of care for shared clients. Coordination can be simplified through the required use of a common SDOH referral platform that brings to government agencies, health plans and hospital systems, and community-based providers as well as supports secure, bidirectional data-sharing, screening for unmet social needs, and closed-loop referrals.</td></tr>
<tr><td colspan="2">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.<br><br>Please offer suggestions for changes that could be made in the new MCO contract that will strengthen FWA prevention, detection, and recovery efforts.</td></tr>
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<tr><td colspan="2">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.<br><br>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?</td></tr>
<tr><td></td><td>In order to further health equity and improve population health for Louisiana's Medicaid population, LDH should consider the following strategies to hold MCOs accountable. - Require MCOs to Utilize a Common SDOH Referral Platform: This infrastructure brings together government agencies, health plans and hospital systems, and community-based providers to address the social determinants of health and connect health and social care for vulnerable individuals. A comprehensive and strong platform should support secure, bidirectional data-sharing, screening for unmet social needs, tracking a person's care journey through closed-loop referrals, and a culturally-sensitive community engagement process. - Require MCOs to Utilize a Standard SDOH Screening Tool for All Members: Unite Us is currently building LDH's Community HealthWays screening tool, a modification on a CMS-developed tool, into the Unite Us platform for community health workers at parish health units to utilize. This screening tool should be utilized with all Medicaid members in order to ensure all needs are being universally identified in all parts of the State. - Offer Funding Flexibility and Guidance for Health-Related Social Services: LDH should encourage MCOs to offer health-related services directly addressing members' social determinants or other community-level interventions aimed at improving population health. Examples of covered services may include housing support services, nutrition classes and transportation services. - Integrate SDOH Measures into Quality Health</td></tr>
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| | Metrics: MCOs should be held accountable for improving health equity in their Medicaid population by tying a proportion of administrative payment to SDOH quality-based metrics. Examples of key performance metrics include potentially avoidable costs, emergency department visits, behavioral health engagement, well visits, prenatal engagement, dental visits, and health neighborhood. - Expand Louisiana's use of home- and community-based services (HCBS) waiver, which offers supportive housing services to reduce homelessness and unnecessary institutionalization among people with disabilities. |
| **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.<br><br>Please offer suggestions for how can LDH hold the MCOs accountable for statewide policy, operational, and financial priorities in the MCO contract. | |
| | In order to increase MCO accountability, we encourage the Louisiana Department of Health to require MCOs to do the following: - Identify and address unmet social needs through universal, mandatory screening; - Build a network of community partners that can deliver clinical and non-medical interventions to adequately address the holistic needs of beneficiaries; - Send referrals to community partners and track whether they were accepted or rejected through closed-loop referrals; - Utilize technology that allows for bi-directional communications so all providers can play an active role in supporting the health of their clients/patients; and - Capture outcomes data on the services that are rendered. This statewide infrastructure should ensure: - Human and healthcare service providers have equal power in determining social care standards and work; - Transparency and accountability across the ecosystem of providers; - Statewide standards in technology, tools, data collection, and reporting metrics; - A single Master Person Index to allow for longitudinal tracking and promotion of a trauma-informed approach to social care delivery; and - Improvements in patient experience and personal health/wellbeing with a focus on eliminating health disparities. In addition, the state can utilize updated quality measures to drive positive change. In Oregon, for instance, the Oregon Health Authority is using quality health metrics to show how well the state's managed care plans are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care. In the State of Washington, the Medicaid Quality Improvement Program (MQIP) requires managed care organizations to partner with public health systems in implementing projects that reinforce high-quality delivery of care and support community health. Under the Medicaid Transformation Project, MQIP incentivizes MCOs with funding to undertake quality improvement projects in areas such as improving maternal and child health outcomes. |
| **Have feedback on an area not represented above? Please provide it below.** | |
| | Unite Us recommends that the Louisiana Department of Health prioritize efforts to address the social determinants of health, the upstream factors often leading to chronic and acute conditions that are far more difficult and expensive to treat. To achieve maximum impact, we urge states to establish statewide coordinated care networks that electronically connect individuals with identified needs to appropriate community resources, emphasizing a coordinated and person-centered approach for delivering care statewide. A common statewide platform brings together state government leaders, health providers, and communities to connect the dots, more effectively collaborate, and target investments in the interventions that are most likely to improve health outcomes. For the general Medicaid populations, this means investing in social service interventions that address health-related social needs or connecting individuals to training and job placement services. For aging populations, this means combating social isolation and ensuring necessary services for individuals who want to age at home. In the justice system, this means investing in improved health access and well-being of justice-involved individuals, through connections to substance use treatment and mental illness support for instance, rather than paying for people to cycle through the system at a great cost to government, families, and communities. A statewide partnership opens the door for connecting social care data and health data in a way that allows the health system to more effectively address health-related social needs and develop insights into where there are inequities in access to services and disparities in health outcomes related to the lack of upstream investments. Building social care infrastructure into the State's overall plan for health system transformation is critical to long-term success in improving health outcomes, lowering costs, and building more equitable communities. |