Louisiana Department of Health (LDH)
628 N. 4th Street
Baton Rouge, LA 70802

Submitted via email: healthy@la.gov

Re: MCO RFP 21

UnitedHealthcare Community Plan of Louisiana appreciates this opportunity, offered by the Louisiana Department of Health (LDH), to provide feedback in preparation for the Medicaid managed care RFP that will be released in 2021.

As longstanding partners with LDH, UnitedHealthcare is honored to support the State in ensuring access to health care, engaging with providers to transform the health care system and investing in our communities to improve health outcomes. By collaborating with the State, more than 25,000 providers, numerous community partners, and nearly 500,000 enrollees and their families, we aim to achieve our mission of helping people live healthier lives in Louisiana.

Our response to LDH's areas of interest is included in the following document. Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me at (504) 849-3523 or karl.lirette@uhc.com.

Sincerely,

Karl Lirette
Chief Executive Officer
UnitedHealthcare Community Plan of Louisiana

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Behavioral Health Integration

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?

Over 90% of Medicaid recipients diagnosed with behavioral health conditions have comorbid physical health conditions[1], amplifying the effect on an enrollee's well-being and making it impossible to adequately address health conditions independently. Further, enrollees' behavioral health is impacted by their social conditions (e.g., housing quality and stability, personal safety and food security). Without an approach to care that integrates physical health, behavioral health and social determinants of health (SDOH), enrollees experience poorer health outcomes and providers become overwhelmed. We offer the following recommendations for LDH to help MCOs better meet enrollees' holistic health care needs.

Network Development

Many physical and behavioral health providers are interested in offering more integrated care; however, moving toward integration is not always an intuitive or easy process. We find that providers are often unclear on how best to proceed or lack the necessary resources. It is important to note that integration exists along a continuum that requires increasing levels of sophistication, resources and commitment. LDH and MCOs can offer tools, guidance and financial incentives as suggested below to help improve behavioral health and physical health integration within provider networks.

- **Offer integration-focused practice transformation support to physical and behavioral health providers**. MCOs can continue to offer this support, including helping providers develop the skill and infrastructure needed to schedule joint appointments, develop shared care plans, conduct effective brief assessments, integrate records, make and follow up on referrals, co-locate services and track outcomes.
- **Develop uniform tools and protocols**. To reduce the administrative burden different MCOs' approaches to practice transformation may place on providers, we recommend that LDH convene MCOs and providers to develop uniform training, tools and protocols. Such tools may include common enrollee assessments (e.g., Screening, Brief Intervention and Referral to Treatment [SBIRT]), quality measures focused on process and outcomes-based integration and data sharing protocols between MCOs and providers.
- **Encourage MCOs to incentivize providers for integration and track progress utilizing the below approaches**.
  - Louisiana uses the Integrated Practice Assessment Tool (IPAT) to assess the level of integration of its providers; however, its use by providers is inconsistent. LDH could consider offering additional training and guidance for both completion of the IPAT and tangible progression along the Substance Abuse and Mental Health Services Administration (SAMHSA) Health Resources and Services Administration (HRSA) continuum.

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0875. Accessed December 22, 2020.

- Encourage MCOs to regularly assess enrollee and provider experiences and make improvements as appropriate.
- Employ alternative payment models and value-based purchasing (VBP) programs to incentivize providers offering integrated care, especially for enrollees with more complex conditions or who are difficult to engage

- **Identify opportunities to strengthen or complement the IPAT** by identifying barriers and opportunities in the following functional areas:
  - Knowledge, attitudes and cross-training needs (e.g., assessing provider knowledge of best practices to address non-complicated behavioral health conditions in primary care)
  - Human resources needs (e.g., access to behavioral health providers at primary care clinics and medical providers at mental health clinics)
  - Access to services (e.g., laboratories for behavioral health practices)
  - Existing processes for integration (e.g., joint rounds on complex medical-behavioral cases, joint treatment team meetings and established procedures for consultations)
  - Existing tools for integration (e.g., brief screening tools, electronic health records)

Care Delivery

As Louisiana seeks to improve integrated care delivery, there are several drivers and levers that can influence how the system serves Louisianans. It is imperative that the State, MCOs and providers work collectively to better integrate the delivery system. We encourage the State to consider which stakeholders have the greatest ability to impact system behavior.

LDH is uniquely positioned to take the following steps to establish a strong programmatic foundation for integration in Louisiana:

- Develop process and outcome quality measures related to integration.
- Allow providers to bill for behavioral health and physical health visits in the same day.
- Identify and approve reimbursement for a list of evidence-based practices that offer behavioral health interventions in primary care.
- Remove reimbursement barriers to integration, including activating CMS's psychiatric collaborative care services CPT codes 99492, 99493, 99494 and Behavioral Health Integration CPT code 99484.
- Allow MCOs increased flexibility to offer in-lieu-of services to best meet the unique needs of communities and individual enrollees.
- Create opportunities for providers to incorporate assessments and interventions related to SDOH into their service delivery.

Providers must be directly responsible and engaged to drive meaningful improvement in integration. We recommend consistency in measurement, incentives and required training for all Medicaid providers to establish clear expectations and priorities within the delivery system. LDH can leverage MCOs to facilitate coordinated system execution of program requirements for providers that:

- Increase trauma screenings through incorporation into existing assessments such as depression (PHQ-9), anxiety (GAD-7) and/or substance use disorder screenings.
- Ensure warm hand-offs between medical and behavioral health providers, primary and specialty care providers, providers and state agencies like Child Protective Services, and

providers and community resources. For additional detail on facilitating information and data sharing with CBOs, see our Health Equity response below.

- Encourage participation in training on implicit bias, integrated care and available tools for delivering holistic care.

MCOs are uniquely positioned to bring forward innovation and capacity-building tools that:

- Support the use of telehealth to ensure access to behavioral and physical health services—particularly specialists—in underserved areas.
- Incentivize integrated care delivery through increasingly sophisticated VBP arrangements. For additional detail on VBP arrangements, see our Delivery System response below.
- Offer providers access to systems that allow them to more easily view and collaborate on an enrollee's entire plan of care.
- Link enrollees with community-based organizations (CBOs) that offer essential support for SDOH including housing, nutritional assistance, employment and educational assistance and transportation.

Care Coordination Services

As providers continue to render more integrated care to enrollees and enrollees experience care that assesses and addresses their holistic needs, gaps in communication and coordination may still exist. We recommend that MCOs adopt the following best practices to continue to strengthen care coordination:

- Stratify enrollees based upon their behavioral, physical and SDOH needs.
- Offer tiered care management commensurate with enrollees' needs.
- Leverage family, CBOs and other local supports to assist in meeting enrollees' needs.
- Refer to community-based social supports or directly address SDOH needs.
- Offer enrollees (including individuals experiencing behavioral health crises) and providers one toll-free number to address their medical and behavioral health needs.
- Promote continuous progress toward integration internally through quality teams, performance improvement projects, initiatives to improve integrated health care and outcomes and quality audits that assess points of integration and holistic assessment.
- Provide a platform or system interface that allows clinical staff to have a comprehensive view of enrollees and their needs.

Child and Maternal Health Outcome Improvement

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.)

Given the complexity of pregnancy, no single solution will improve maternal and child health; however, we can make the greatest collective impact by focusing on enrollee engagement and support, better access to and coordination of care, equity, prevention and dissemination of evidence-based practices. Our recommendations are offered below.

Enrollee Engagement and Coordination of Care

Pregnant Medicaid enrollees are often balancing multiple demands on their time and energy and face complex social barriers, making it challenging for them to keep up with prenatal care or meaningfully engage with their MCO. Further, lack of coordination across systems—including providers, MCOs and CBOs—creates unnecessary complexity for these enrollees. Closer coordination across the health care delivery system, stronger community-based support and streamlined communication methods could make it easier for these enrollees to engage in care and reduce redundancy and complexity in the system. Pregnant enrollees will benefit from various elements already highlighted in other sections of this response, including but not limited to integration of physical and behavioral health, addressing health inequities and addressing social determinants of health. However, the following are specific strategies to support pregnant enrollees:

- **Encourage providers to share comprehensive assessments with MCOs.** Providers are a critical and influential part of an enrollee's pregnancy journey. Obstetric (OB) risk assessment forms (OBRAF) completed during OB visits are often the first and earliest source of enrollee identification for MCOs. Ensuring assessments are standardized, comprehensive (including medical, behavioral and social needs) and promptly shared with MCOs will facilitate earlier identification of moms and better information sharing. This will prevent redundancies and allow MCOs to more quickly connect moms with the resources they need and support better enrollee engagement.
- **Support digital communication strategies.** As enrollee communication preferences continue to shift toward digital platforms, providers and MCOs will need to adopt mobile-friendly strategies to encourage engagement, particularly with pregnant Medicaid enrollees. It will be important for the State to help ensure rules and regulations support the use of platforms like telehealth and two-way texting, within HIPAA guidelines.

Maternal and Infant Outcomes and Racial Disparities

Pregnant women in the United States increasingly experience adverse maternal and infant health outcomes. The March of Dimes has given Louisiana a preterm birth grade of "F" and notes that preterm birth rates among black women is 55% higher than the rate among all other women[2]. Infants born preterm are at an increased risk for experiencing physical disabilities and developmental impairments throughout their lives. There is growing evidence on the causes and opportunities to address these disparities. To address poor outcomes and racial disparities in Louisiana that are tailored to specific populations, LDH could convene MCOs, providers, and CBOs to develop and deploy strategies to improve maternal and infant health outcomes among specific Medicaid populations. Some specific opportunities are highlighted below.

- **Disseminate AIM Safety Bundles to standardize care.** The Alliance for Innovation on Maternal Health (AIM) program is a national, data-driven quality improvement initiative based upon proven approaches to improve maternal safety and outcomes in the U.S. Broader adoption of AIM Maternity Safety Bundles[3] can help standardize care and prevent adverse outcomes such as severe maternal morbidity. As seen in California, state Perinatal Quality Collaboratives can be particularly effective in adoption of such bundles. The Louisiana Perinatal Quality Collaborative could work with LDH, MCOs and providers to support broad adoption of the bundles in Louisiana.

[2] https://www.marchofdimes.org/peristats/tools/reportcard.aspx?frmodrc=1&reg=22. Accessed December 23, 2020.
[3] https://safehealthcareforeverywoman.org/council/patient-safety-bundles/maternal-safety-bundles/. Accessed December 22, 2020.

- **Encourage implicit bias training among providers.** There is growing recognition of the role implicit bias may play in the quality of provider care and health disparities. As suggested in other parts of this response, we recommend the State require or encourage providers to engage in implicit bias training to increase awareness and identify opportunities for improvement.
- **Encourage and incentivize non-traditional models of care.** There is growing evidence to support the value of doulas, group prenatal care, home visiting programs and birth centers in improving maternal and infant outcomes (see below). We encourage the State to enable access to these providers and facilities through new coverage and reimbursement policies.

Support for Non-Traditional Models of Care

- Studies have shown that support from non-traditional providers such as doulas and midwives is associated with lower cesarean rates, fewer obstetric interventions, fewer complications, less pain medication, shorter labor and higher scores on the APGAR test.
- The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine have referred to doulas and other support personnel as one of the most effective tools to improve labor and delivery outcomes.
- The Centers for Medicare and Medicaid Services and the Health Resources and Services Administration both have expressed their support for home visiting in a joint brief on the benefits of coverage for home visiting programs both pre- and post-partum where they also described existing authorities available to states to use in developing their home visiting programs.
- The birth center model of care has been shown to be a high-quality care option for women with low-risk pregnancies that can often have lower costs than hospital births.

Support for Special Populations & Coverage Considerations

Pregnant women and children can have a multitude of medical, behavioral, and social conditions that warrant specialized attention and services. The following are strategies to support three such populations that are the largest cost drivers for the State: pregnant women with substance use disorders (SUD), preterm births and infants admitted to the Neonatal Intensive Care Unit (NICU).

- **Ensure care for pregnant women with SUD.** Pregnant women with SUD have distinct risks and treatment needs that should be considered in building the State's SUD treatment infrastructure. For example, the postpartum period is a particularly vulnerable stage for relapse for pregnant women with Opioid Use Disorder (OUD). It can also be difficult for these enrollees to access treatment given heightened stigma for some providers in offering Medication Assisted Treatment (MAT) to pregnant women. The state could facilitate appropriate care for these moms and their babies during pregnancy and one year postpartum by extending eligibility and developing alternative payment methods to encourage providers to offer OUD treatment to pregnant enrollees.
- **Prevent Unnecessary NICU Admissions.** In addition to the substantial costs associated with unnecessary NICU admissions, there is increased risk for infants admitted to the NICU posed by iatrogenic infections and the disruption of mom-infant bonding and breastfeeding. We encourage LDH to continue partnering with MCOs to prevent unnecessary NICU or Pediatric Intensive Care Unit (PICU) stays. We also encourage the State to examine their policies to support MCOs in performing utilization management to ensure only infants meeting medical necessity criteria are admitted to

the NICU. Further, it is essential that health care facilities have appropriate protocols in place to ensure only those who need NICU care are admitted.

- **Coverage Considerations.** We recommend that the State, in partnership with MCOs and community partners, continue efforts to reduce preterm births—including providing access to family planning services, which are essential in decreasing unintended pregnancies. Additionally, providing extended coverage one year postpartum allows moms continued access to necessary physical and mental health services. These services are critical in addressing factors that contribute to maternal mortality, such as depression and addiction.

Mitigating Trauma and Adverse SDOH

It is critical that Medicaid enrollees have access to a robust network of providers who understand the unique needs of individuals who are experiencing or have experienced trauma and extreme poverty. We recommend that MCO networks include providers who are trained in and employ current evidence-based practices to address trauma (e.g., sexual, psychological and physical abuse or neglect).

Delivery System Reform

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.

We encourage LDH to allow greater MCO flexibility to design innovative VBP models that ensure enrollee needs are addressed and providers are appropriately supported and incentivized. MCOs should tailor agreements and related supports to fit mutual needs. Our provider partners are in different stages of their journey toward accountability for outcomes. More providers are likely to participate in increased levels of performance compensation or risk when MCOs use their tools and expertise to inform individual agreements based upon provider readiness, scope of practice and patient population. Further, the flexibility to meet providers where they are and invest in their capacity to become more effective partners in managing care will be essential for future delivery system transformation, given the impact of the pandemic.

To ensure innovative models facilitate improvements and produce the desired system and enrollee outcomes, we recommend that LDH prioritize the value new models are producing rather than setting a target tied to the portion of dollars paid through specific agreements or the volume of arrangements. LDH could also work with the MCOs to develop an evaluation strategy for determining the efficacy of payment arrangements.

Further, UnitedHealthcare recommends LDH consider the following opportunities to facilitate delivery reform by balancing innovation with the standardization of core elements for a simplified provider experience:

- **Consistent quality metrics across MCOs.** We encourage LDH to partner with MCOs, providers, enrollees and other stakeholders to develop a common set of quality metrics across all MCOs and aligned to current or future contract requirements. The benefits of collectively selecting measures that are clinically meaningful and easily measurable include administrative simplicity for providers and mitigation of differing MCO approaches that could hinder broader progress toward delivery system transformation. These quality metrics should be inclusive of the integration metrics.
- **Consistent Patient-Centered Medical Home (PCMH) definition across MCOs.** Managed care has long recognized the opportunity to increase access to higher quality primary care through payment models that incentivize PCMH activities. To support

consistent expectations across MCOs and facilitate each PCP's move toward value, we recommend LDH formally define PCMHs by adopting the recognition set by National Committee for Quality Assurance (NCQA). This is a national standard, and several practices in the state have already become NCQA-recognized. If this recommendation is adopted, MCOs can support providers to become PCMH-certified. We encourage those who do not become PCMH-certified to adopt the practices that are advanced by the PCMH model.

Disaster Planning and Recovery

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.

Enrollees encounter many barriers to obtaining health care services and maintaining healthy routines when faced with disaster, whether it be a natural or man-made occurrence. In some instances, obtaining the basic necessities to sustain life such as food, clean water and safe shelter becomes a challenge. MCOs can play a vital role in connecting enrollees with resources in their communities, some of which are continually adapting as the disaster and the response to the disaster change over time. Further, access to care is enhanced when providers have consistent and simple disaster response protocols in place. We offer the following suggestions to ensure enrollees are cared for during disaster events.

- **Develop a comprehensive and individualized disaster plan.** Documentation of enrollee care needs is critical to ensuring their care can be coordinated and continued in the midst of a disaster. We recommend that MCOs integrate disaster preparedness into their assessments to help enrollees establish a comprehensive and individualized disaster response plan and to ensure enrollee resources are documented in the event of a disaster.
- **Identify high-risk or displaced enrollees.** Appropriate diagnosis coding and SDOH screening by direct care providers and MCO case managers is imperative to identifying enrollees who may need outreach and support prior to, during and after a disaster. When MCOs are able to integrate accurate coding into the enrollee's disaster response plan, it enables MCO case managers to more effectively anticipate, individualize, and address needs as they evolve in the midst of disaster. For enrollees who find themselves displaced due to a disaster, and who were not considered at risk and therefore not identified for initial outreach, care coordination is vital in assisting the enrollee in re-establishing care in a new environment temporarily and for those transitioning back into their community post-disaster.
- **Ensure access to providers.** Enrollees need access to telehealth and, when available, providers who have access to their electronic medical record (EMR) to facilitate smoother transitions between providers in a disaster. MCO case managers can be indispensable in connecting enrollees with telehealth options if their primary providers are not available, whether live or via telehealth. Case managers are instrumental in reconnecting enrollees with providers, as we often have teams working to document provider status and availability as the networks re-establish themselves.

DOJ Settlement Agreement Requirements

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.

The safety, continuity of care and support of persons with Serious Mental Illness (SMI) who reside in nursing facilities and who want to transition back into their communities is of the utmost concern. Enrollees may want to leave the nursing facility, but do not always have the support needed to succeed and may need skill development prior to and during transition. Enrollees may do well in the beginning, but over time the effects of SMI may impact their safety and jeopardize their ability to remain independent. Others will have difficulty finding supportive environments. Specific strategies for addressing this issue include:

Recommendations for LDH to Consider

- Persons with SMI need supportive or transitional housing that offers supervision or the ability to monitor for risk/prevent crisis when moving from a nursing facility into the community. Unfortunately, there are not enough supportive or transitional housing facilities to accommodate the need, and many of the existing homes are not certified. We recommend that LDH consider restructuring the reimbursement system to allow and encourage more group homes, therapeutic settings, and supervised housing accommodations for enrollees transitioning from the nursing home to the community.
- To improve transitions into the community, we recommend LDH consider restructuring the reimbursement system for day programs that provide supervisory settings and skill-building for persons with SMI.

Recommendations for MCOs

- Encourage and support providers' use of evidence-based therapeutic interventions for the SMI population.
- Ensure enrollees can be supported through multiple programs such as assertive community treatment (ACT), intensive outpatient treatment programs (IOP) or partial hospitalization programs (PHP) as long as there is no duplication of effort.
- Establish a community-based representative (e.g., an assigned guardian) who can swiftly prepare for and respond to enrollee needs prior to discharge. Further, explore the possibility of collaborating with state agency contracted support coordinators in the community.
- Continue to incentivize, reimburse and support direct-to-enrollee telehealth.
- Create routine multidisciplinary rounds with all stakeholders involved in the care of high-risk enrollees in the My Choice LA program.

Fraud, Waste and Abuse Initiatives

Please offer suggestions for changes that could be made in the new MCO contract that will strengthen FWA prevention, detection, and recovery efforts.

The goal for every Medicaid program is to ensure enrollees receive the care they need, and providers are paid promptly and accurately for their services. However, fraud, waste and abuse (FWA) persist in Medicaid billing and payment systems nationwide. To strengthen FWA prevention, detection, and recovery efforts we suggest LDH convene MCOs and providers to identify flexible solutions that leverage MCOs' tools and capabilities while minimizing provider abrasion. When done collaboratively, this would help preserve the integrity of the Medicaid program, resolve problems before they become issues, and identify opportunities for preventive FWA activities.

We also recommend that LDH implement measures that encourage MCOs to proactively address FWA. Requiring MCOs to wait on guidance from LDH based upon encounter data could increase risk of FWA and limit MCOs' ability to rapidly and meaningfully address

concerning patterns and protect taxpayer dollars. The following suggestions are just a few opportunities for consideration:

- Require MCOs to measure and report metrics to ensure enrollee access to behavioral health and proactively identify behavioral health billing issues. Specific metrics could be inferred by LDH based upon recent legislative audit results.
- LDH already requires MCOs to review non-emergent medical transportation (NEMT) without related claims for a covered service. LDH could add to its contract a requirement to report, perhaps quarterly, the results of this type of audit.
- LDH could implement standard monitoring and reporting for NEMT, similar to the Program Integrity system used to collect and share metrics from all the MCOs. This could help MCOs with data analytics, identification of "bad players," and coordination of Detection and Correction efforts.
- If these suggestions are implemented, we encourage LDH to consider allowing these costs to be included in the numerator of the Medical Loss Ratio (MLR). This would continue to ensure sustainability of the managed care program and financial stability of MCOs.

Lastly, we recommend LDH consider creating a standard credentialing process, aligned with the American Society of Addiction Medicine (ASAM) criteria, to ensure enrollees with SUD/OUD have access to quality care across all types and intensities of services. Other states such as Florida, New York, and California have struggled with low-quality addiction treatment providers who offer abstinence-only treatment for OUD and/or commit FWA. While MCOs would still be required to conduct due diligence and credential providers based upon their NCQA accreditation requirements, implementing an additional, standardized, ASAM-based credentialing process would combat this potential for abuse while holding providers to clear standards across all MCOs and all levels of care. This standardized approach will likely expedite the timeframe for credentialing, minimize provider administrative burden and lead to increased provider capacity across levels of care.

Health Equity

Please offer suggestions for how LDH can require the MCOs to focus on addressing social determinants of health and other health disparities in Louisiana.

In addition to our recommendations relating to health equity offered in other sections, we recommend that LDH consider the following components to achieve a comprehensive, coordinated system to address SDOH and health disparities:

- **Adopt a standardized SDOH screening tool for all providers and CBOs, focused on key state priorities.** LDH could work with enrollees, providers, CBOs, and MCOs to develop or select a standardized screening tool (such as PRAPARE) to capture enrollee SDOH needs (e.g., housing, transportation, food insecurity and interpersonal safety) and enrollee preferences (e.g., self-identified race and gender, primary language, preferred communication method and other factors). This standardized tool would enable a shared understanding across providers, MCOs and CBOs of enrollees' most critical social needs and individual care preferences. Improving SDOH data accessibility will facilitate appropriate program coordination and connection to appropriate resources. Consistent SDOH data collection and storage methods across social service programs will afford MCOs the opportunity to test interventions and employ predictive analytics to connect the individuals most in need with the right resources.

- **Facilitate bidirectional transfer of meaningful, workable data.** LDH has an essential role in enabling the data sharing across MCOs, providers, and CBOs that is necessary to support a person-centered experience. Greater connectivity will facilitate the sharing of accurate, comprehensive enrollee data and allow stakeholders across the health care system to focus on enrollee needs. This expanded capacity will help ensure accurate diagnoses, treatment decisions and options and early identification of inconsistencies, duplications, and failures. We recommend LDH work to enhance the ability for us all to share critical care coordination data (e.g., screenings, assessments, care plans) and to track SDOH needs through a platform like North Carolina's NCCare360. Any approach to improving data infrastructure must have active and ongoing engagement from CBOs to succeed.

NCCare360

NCCare360 is a statewide public-private partnership between the North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation that gives CBOs the ability to simplify communication, referral processes, and payment by centralizing all data sharing through a single source. NCCare360 uses a closed feedback loop to inform health plans, providers and CBOs that social services and supports have been provided to enrollees. The platform also has the potential to allow for direct service payments to community-based organizations and creates the IT infrastructure for data collection to build new alternate payment/VBP models for social services and supports.

How can LDH best hold the MCOs accountable for significantly improving health equity among Medicaid managed care enrollees?

Health equity must be an overarching principle for MCOs and providers working to improve population health. To reduce the effect of health care disparities, we recommend that MCOs:

- **Analyze and report data on health disparities.** By understanding where specific disparities exist, MCOs can work with providers and communities to develop targeted interventions that are locally relevant. We recommend that LDH consider creating a platform to collect and publish MCO and provider performance data stratified by race, ethnicity, geographic area, and primary language. Such a platform will enable LDH to highlight disparities experienced by the Medicaid population and identify opportunities for collective improvement.
- **Verify provider awareness of health disparities.** As discussed in other sections, educating providers on racial, ethnic, and geographic disparities that exist in their patient population is a critical first step to engaging them as partners in addressing these disparities. MCOs can partner with CBOs, providers, and health departments to offer tailored training based upon each parish's most influential disparities. For example, MCOs can continue to support the development of trainings on institutional racism and how to address racial bias and unconscious bias for providers, particularly those in parishes with high rates of infant and maternal mortality for African American infants and moms such as Caddo and Orleans Parishes.
- **Engage in quality initiatives and VBP partnerships with providers.** Health equity must be an overarching principle for MCOs and providers working to improve quality and population health. LDH, MCOs, providers, enrollees and CBOs should collaborate on quality initiatives to improve health equity, particularly as it relates to race and ethnicity. This is an opportunity to evaluate the available data on racial/ethnic health disparities, standardize the collection and sharing of data on priority SDOH elements and

incorporate aligned social risk measures. This will create a foundation for future payment models that can reward providers and CBOs for clinical and social interventions that advance health equity and address social risk factors.

- **Develop and deliver on collective action plans to address disparities.** MCOs can partner with CBOs and providers to enhance existing community efforts that address the underlying causes of health care disparities. The collective impact model is a framework through which MCOs can contribute funding and data analytics while accelerating the implementation of community-based strategies by partnering with trusted CBOs and providers.

Health Equity and COVID-19

The incidence and mortality rates of COVID-19 have been disproportionate across racial and ethnic groups. Specifically, non-Hispanic African Americans and Latinx individuals have higher rates of incidence, hospitalization and death from COVID-19 compared to non-Hispanic whites. As the COVID-19 vaccination becomes more readily available, we encourage LDH to leverage MCOs and providers to help promote and support distribution of the vaccine, especially to marginalized populations such as low-income African Americans and Latinx individuals. Specifically, we offer the following recommendations:

- **MCOs should partner with CBOs to tackle historical distrust of the health care system and/or vaccines.** Marginalized populations often have a significant distrust of the medical community, which could prevent acceptance of the COVID-19 vaccine. To improve COVID-19 vaccine acceptance in traditionally marginalized communities, MCOs can leverage existing CBO relationships to develop and deploy strategies to reduce vaccine hesitance and instill trust in the vaccine. For example, non-clinical community leaders could provide communication and education on the importance of vaccines and support efforts to increase vaccination rates.
- **MCOs should support enrollees in care management.** To ensure the most vulnerable enrollees receive necessary information about the COVID-19 vaccine, MCO case managers should provide enrollees who are engaged in care management with information about the efficacy and safety of vaccines and where to go to get the vaccine. This information should be reinforced by the enrollee's care team.
- **MCOs can help ensure timely information and access to LINKS.** The Louisiana Immunization Network (LINKS) will be critical in tracking adherence for both the initial COVID-19 vaccine and the second dose. If MCOs and providers are not required to submit claims, billing, or reimbursements for the COVID-19 vaccination, MCOs will need to rely on LINKS to verify that enrollees have received it. MCOs can provide education to providers who may not have access to LINKS to enhance documentation and appropriate follow-up vaccination. LDH, MCOs, and providers should work together to ensure that COVID-19 vaccines are entered timely, especially given the second dose requirement. MCOs could also work with providers to ensure they are registered in the COVID-19 Vaccination Program to allow them to administer the vaccine.
- **Stakeholders should develop and deliver unified messaging.** LDH could convene MCOs, providers, CBOs, and local health departments to develop a coordinated messaging campaign highlighting the importance of vaccines and dispelling misinformation and vaccine myths.
- **Providers should receive implicit bias training.** As mentioned elsewhere in this document, it is critical that providers engage in implicit bias training to increase awareness and identify opportunities for improvement.

- **LDH could leverage NEMT to provide transportation to receive vaccines.** LDH could allow for transportation to become an allowable expense by MCOs to help enrollees with transportation barriers receive their COVID-19 vaccinations. MCOs could also support this effort by providing education and messaging about steps drivers can take to protect themselves and their passengers from COVID-19.

Increased MCO Accountability

Please offer suggestions for how can LDH hold the MCOs accountable for statewide policy, operational, and financial priorities in the MCO contract.

MCOs play a critical role in enabling states to deliver higher quality care, improve health outcomes for Medicaid enrollees and manage healthcare costs. The structure of managed care incentivizes and holds MCOs accountable for improving population health—through care coordination, preventive care and other measures—which keeps the focus on quality and value of care.

An important indicator of MCO accountability is enrollees' satisfaction with their experience. We recommend that LDH convene stakeholders, including enrollees, providers, CBOs, and MCOs, to define a small set of meaningful enrollee experience measures. To hold MCOs accountable, LDH could require reporting on these measures in the initial years to establish a baseline and then include them in MCO quality incentives.

Similar to the suggestion offered in our response to promote delivery system reform, we encourage LDH to consider adapting existing quality benchmarks to align MCO performance with state priorities and including all services to incentivize whole-person care approaches. We recommend using performance measurements that reflect national standards (e.g., NCQA or National Quality Forum), wherever possible. The design of performance measures should encourage acceptance by and participation of the provider community and center on enrollee preferences and priorities. Additionally, these measures should be appropriate to the populations being served. Potential measures for consideration include:

- Enrollee experience satisfaction (as discussed in the above paragraph)
- Provider satisfaction and reduced administrative burden
- Timely and accurate claims payment
- Network sufficiency and ability to fill network gaps
- Quality strategy for filling gaps in care

These indicators help measure performance from an operational level; however, we encourage LDH to also measure MCOs' ability to innovate and drive meaningful performance towards making Healthy Louisiana a sustainable, effective and cost-efficient program.

Metrics that are aligned with financial incentives and targets have demonstrated efficacy in improving the health of Medicaid enrollees. We support the use of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures for assessing performance around the following areas/domains:

- Improvement in enrollee health
- Enrollee access to care
- Quality and effectiveness of care provided to enrollees
- Overall and appropriate utilization of care
- Overall enrollee and provider experience