FUTURE OF MEDICAID MANAGED CARE: FORUM FOR PUBLIC INPUT ON DESIGN OF 2019 REQUEST FOR PROPOSALS

March 2018
FORUM PURPOSE

- For LDH to present key design elements under consideration for the next generation of Medicaid managed care contracts

- For members of the public to provide input on the future design of the Louisiana Medicaid program for LDH consideration in its development of the next managed care Request for Proposals
STATE PROCUREMENT LAW LIMITS

- Designed to ensure a competitive bid process that is open, fair, and transparent

- Limits State communications from the beginning of RFP development to the public release of the RFP
  - Permits responses in general terms, providing a broad overview with no specific details
  - Permits listening sessions with interested parties to gain information for consideration
  - Prohibits a back and forth over RFP specifics, discussion of what the State intends to include or exclude from RFP
RULES OF ENGAGEMENT

LDH will:

- Assume forum participants are experienced with Medicaid in general and Medicaid managed care in particular
- Provide general information on the next Medicaid managed care RFP process and timeline
- Outline key design elements under consideration for the RFP
- Invite forum participants to share their views on the content development for the next RFP, with a focus on key design questions
FOCUS ON THE FUTURE

➢ To maintain focus on the RFP, LDH will respectfully redirect questions/concerns about current managed care operations to other venues for resolution

➢ For provider issues, contact ProviderRelations@la.gov

➢ For member or other issues, contact Healthy@la.gov
PROCUREMENTS, CONTRACTS TO DATE

- **Past** – 1st generation, original “Bayou Health” contracts
  - 2011 Request for Proposals for “Coordinated Care Networks”
  - Physical and basic behavioral health, with pharmacy carve in
  - 2 Primary Care Case Management “Shared Savings” plans + 3 Managed Care Organization “Prepaid” plans
  - 3-year contract term, 2/1/12-1/31/15

- **Present** – 2nd generation, current “Healthy Louisiana” contracts
  - 2014 RFP for Managed Care Organizations
  - Physical health, with specialized behavioral health carve in
  - 5 MCOs
  - 3-year contract term, 2/1/15-1/31/18
  - 2-year contract extension, 2/1/18-12/31/19
CURRENT CONTRACTORS

Healthy Blue
UnitedHealthcare
AmeriHealth Caritas
Aetna Louisiana
AETNA BETTER HEALTH® OF LOUISIANA
Healthy Louisiana
FUTURE PROCUREMENT, CONTRACTS

- 3rd generation contracts
  - 3-year contract term, 1/1/20-12/31/22

- Tentative procurement process/timeline

<table>
<thead>
<tr>
<th>Release RFP</th>
<th>Whitepaper/Conduct Public Engagement</th>
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<tbody>
<tr>
<td>Complete Market Research &amp; Finalize RFP</td>
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<tr>
<td>Publish RFP (January 2019)</td>
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<td>Evaluate RFP Responses &amp; Recommend Awardees</td>
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<td>Negotiate &amp; Execute Contracts</td>
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<td>Conduct Readiness Activities</td>
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<td>Go-Live with Future Program (January 1, 2020)</td>
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We’re Here!

Q1-Q218 Q318 Q418 Q119 Q219 Q319 Q419 Q120
PROCESS FOR PUBLIC INPUT

Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care

Future Vision and Policy Considerations for Public Engagement
➢ Review white paper content
  ▪ Vision
  ▪ Objectives
  ▪ Key design elements

➢ Open microphone for public comment on the questions listed under any of the 12 key design elements

➢ Comment cards provided for written feedback
VISION FOR THE FUTURE

LDH will partner with enrollees, providers, and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care) and effectively manages Medicaid per capita care costs (lower costs).
OBJECTIVES

1) Advancing evidence-based practices, high-value care and service excellence

2) Supporting innovation and a culture of continuous quality improvement in Louisiana

3) Ensuring enrollees ready access to care, including through non-traditional means such as medical homes and telehealth

4) Improving enrollee health

5) Decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs

6) Using a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address social determinants of health

7) Reducing complexity and administrative burden for providers and enrollees

8) Aligning financial incentives for plans and providers and building shared capacity to improve health care quality through data and collaboration

9) Minimizing wasteful spending, abuse and fraud
# KEY DESIGN ELEMENTS

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<tr>
<th>Key Design Elements</th>
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<td>(a) Limit the number of statewide MCOs</td>
<td>(g) Improve care management/care coordination at MCO and provider levels</td>
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<td>(b) Expect MCOs to operate as innovators to achieve the Triple Aim</td>
<td>(h) Increase focus on health equity and social determinants of health</td>
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<td>(c) Enhance network adequacy and access standards</td>
<td>(i) Promote population health</td>
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<td>(d) Invest in primary care, timely access to care, telehealth, and medical homes</td>
<td>(j) Apply insights from behavioral economics to facilitate enrollees’ healthy behaviors and choices</td>
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<tr>
<td>(e) Improve integration of physical and behavioral health services</td>
<td>(k) Improve approach to value-added benefits</td>
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<td>(f) Advance value-based payment and delivery system reform</td>
<td>(l) Achieve administrative simplification</td>
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LIMIT THE NUMBER OF STATEWIDE MCOs

What are your recommendations on the maximum number of statewide MCOs the state should contract with for Medicaid?
EXPECT MCOS TO OPERATE AS INNOVATORS TO ACHIEVE THE TRIPLE AIM

- How can MCOs offer innovations to reduce program complexity, administrative burden, and unnecessary costs and to improve care and population health in partnership with providers and patients?

- How can the procurement best advance evidence-based care and meet the Triple Aim?
ADMINISTRATIVE SIMPLIFICATION

- Please offer specific ideas for achieving LDH’s aim for greater administrative simplification in its Medicaid managed care program by reducing the burden and complexity of the program for enrollees.

- What are your ideas to make the program less burdensome for providers by reducing paperwork, redundancies, and improving clarity of clinical criteria?
INVEST IN PRIMARY CARE, TIMELY ACCESS TO CARE, TELEHEALTH, AND MEDICAL HOMES

- How can successful bidders demonstrate initiatives that would meet LDH’s goal to improve enrollee access to primary care, and LDH’s desire for increased practice transformation into medical homes?

- How might LDH encourage or require contracted MCO’s use of telemedicine or telehealth, and e-visits to improve enrollee access to care?

- How might LDH encourage or require MCOs to adopt effective triage lines or screening systems, or other technology to help improve access and coordination of care?
IMPROVE CARE MANAGEMENT/CARE COORDINATION AT MCO AND PROVIDER LEVELS

- Please offer suggestions for functions and elements related to improving care management and coordination at both the MCO and provider levels.

- Provide your opinion on whether MCOs should be required to employ, support, and/or utilize Community Health Workers for certain populations and care management interventions.
IMPROVE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES

- Please offer suggestions for key aspects of behavioral health and physical health integration and how LDH could ensure that successful bidders offer and support improved integration of behavioral health and physical health care delivery for enrollees in this upcoming procurement.

- What specific network development, care delivery and care coordination approaches might LDH encourage or require MCOs to employ to better meet enrollees’ behavioral health needs?
ENHANCE NETWORK ADEQUACY AND ACCESS STANDARDS

What are your suggestions for changes to enable LDH and its contracted MCOs to improve and ensure enrollees’ ready-access to covered services, especially in rural and underserved areas?

What types of reporting and monitoring of MCO provider networks would you recommend to better assess the adequacy and timeliness of access to care for Medicaid MCO enrollees?
Please offer suggestions for how best to incent Medicaid MCO enrollees for healthy behaviors and medical compliance and/or share experiences applying behavioral health economics in other insurance settings.
- Adult Vision (21+)
  - Eye exam
  - $ towards glasses or contacts

- Adult Dental (21+)
  - Dental exams and cleanings
  - Filling and extractions
  - X-rays

- Weight Management (adults and peds)
  - Appointments with dieticians
  - Gym memberships
  - Weight Watchers meetings

- Cell phone

- Rewards for healthy behaviors
  - Debit/gift cards for annual preventive care, wellness screenings, prenatal/postpartum exams

- Pharmacy
  - No/reduced co-pays
  - Over the counter drug coverage
Please offer suggestions related to whether and how MCOs should be able to offer value-added benefits and services at no additional costs under the next procurement.

Should value-added benefits apply to enrollees, providers, or both?
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<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
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<tr>
<td>FEE FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION - BASED PAYMENT</td>
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<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Shared Savings</td>
<td>Condition-Specific Population-Based Payment</td>
<td>Comprehensive Population-Based Payment</td>
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<td>(e.g., care coordination fees and payments for HIT investments)</td>
<td>(e.g., shared savings with upside risk only)</td>
<td>(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td>(e.g., global budgets or full/percent of premium payments)</td>
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<tr>
<td>Pay for Reporting</td>
<td>APMs with Shared Savings and Downside Risk</td>
<td>Comprehensive Population-Based Payment</td>
<td>Integrated Finance &amp; Delivery Systems</td>
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<td>(e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>(e.g., global budgets or full/percent of premium payments in integrated systems)</td>
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Please offer suggestions on how contracted MCOs can best promote adoption of new payment methodologies that reward providers for the value they create as opposed to fee-for-service methodologies that reward providers for the volume of services they provide.

Please comment on provider readiness to participate in VBP arrangements, including ACOs, by 2020. What support should LDH or its MCOs make available to providers?

Please suggest policies for the MCO model contract related to Medicaid ACOs criteria for ACOs, and/or the respective roles of ACO, MCO and LDH.
PROMOTE POPULATION HEALTH

- What requirements should be placed on MCOs in terms of utilizing a population health approach to care delivery?
- What are the key aspects that should be included within a population health strategic plan?
Please offer suggestions for ways that LDH can utilize the upcoming managed care procurement to increase MCO focus on social determinants of health and improve health equity.
➢ Respond to LDH Whitepaper

*Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care*

http://www.ldh.la.gov/assets/HealthyLa/LDH_MCO_RFP_WP.pdf

➢ Email responses to healthy@la.gov

➢ Responses due by April 17, 2018 at 2 p.m. Central Time
QUESTIONS?