LOUISIANA HOSPITAL ASSOCIATION

9521 BROOKLINE AVENUE ◆ BATON ROUGE, LOUISIANA 70809-1431
(225) 928-0026 ◆ FAX (225) 923-1004 ◆ www.lhaonline.org

May 31, 2017

Ms. Jen Steele
Medicaid Director
Louisiana Department of Health
P.O. Box 91030
Baton Rouge, LA 70821
Email: jen.steele@la.gov

Dear Ms. Steele:

On behalf of our member hospitals and health systems, the Louisiana Hospital Association (LHA) appreciates the opportunity to provide input on the state's Medicaid managed-care programs. Included in this letter are recommendations, based on feedback from our membership, that should be considered as Louisiana Medicaid approaches the next managed-care contracting period. After five years of experiences and lessons learned in what is now the Healthy Louisiana program, the LHA makes the following recommendations:

Procurement Process

The LHA recommends that the Louisiana Department of Health (LDH) reduce the number of contracted managed-care plans. One of the chief issues our members have encountered in the existing program is the increased workload and costs associated with multiple administrative processes imposed by each plan. Reducing the number of plans would greatly lessen the current administrative burden on providers. In addition, limiting the program should help to eliminate some of the weaker program networks and provide for a more comprehensive coverage option for those enrolled in the Medicaid managed-care networks.

Program Funding and Performance

In light of funding challenges that currently exist in the Louisiana State Medicaid program preserving adequate funding is imperative. LHA's stated concern in 2012 and 2014 was that the Per Member Per Month (PMPM) payment levels for the managed-care program were implemented on the heels of significant reductions to Medicaid base payment rates. If the Department is committed to the success of Medicaid managed care, adequate funding for healthcare services in the form of health plan and provider payments is imperative. In addition to proper funding of the Medicaid program, monitoring how that money is spent is equally important. The term "value-based purchasing" is utilized by the Department quite frequently in the context of services purchased from providers. The Department should employ similar concepts to create more accountability with the managed-care organizations. The following sections provide specific program operational recommendations:

Administrative Simplification

Since the Department began implementing managed care, the LHA and other provider groups have advocated for administrative simplification. Where there was once a single process, there are now five additional processes for rendering care to Medicaid patients. There are vast opportunities for efficiency and standardization within the Medicaid managed-care program. Some of the ongoing issues that should be addressed through standardization include, but are not limited to:

- **Standardized Credentialing:** In addition to completing six different processes and, completing six different Disclosures of Ownership, providers are forced to endure the multiple plan-level questions that may occur during credentialing. The implementation of a standardized credentialing process would not only reduce administrative burden, but also reduce the timeframes in which providers are approved and accessible to Medicaid enrollees.

- **Clinical Guidelines/Criteria:** Different plans use different clinical criteria (Milliman, Interqual, etc.) for determining medical necessity. There is no reason this should not be standardized within the Medicaid program. In addition to the costs providers must bear in licensing and staff training to be fluent in multiple sets of clinical criteria, managing to these differing sets is an administrative burden that could be resolved by instituting a single standard.

- **Process/Requirement Change Notification:** Many health plans changes are communicated via "fax blast." Exploration of more efficient forms of electronic communication for these type notices should be undertaken.

Clinical Communication Improvements

While this section could be considered a subset of administrative simplification, there are enough issues on this front to warrant significant attention in the reprocurement process.

- **Clinical Information Submissions:** Today, hospitals are required to provide multiple clinical submissions before plan decisions on authorizations are rendered. Plans should be required to render decisions on submitted information before requiring additional information from hospitals. Plans should also be required to render concurrent review decisions on the same day as clinical information is provided, or no later than 10 a.m. the next day if information is provided late in the day.

- **Denial Communication Delays:** Currently, late communication of health plan denials and paper letters impede the provider appeals process. While implementation of a standardized appeal/independent review process will help, there are other opportunities such as streamlining denial communication and enforcement of communication timeframe requirements should be enhanced.

- **Observation:** Observation is one example of a service for which there are multiple plan definitions, applications, timing and requirements. Identifying these inefficiencies and creating standard application of how covered Medicaid services are approved, processed and paid would be a step in the right direction of reducing administrative burden and costs in the program.

- **Pre-certification and Notification Requirements:** While the volume of services that require prior authorization by plan varies, the number is significant. Identifying and removing prior-authorization requirements for services with extremely high approval percentages, creating standardized requirements for these processes, and standardization of notifications would improve the overall efficiency of the program.

Payment Mechanisms

In the existing managed-care program, LDH implemented the following mechanisms relative to protecting providers' reimbursement. The LHA recommends that the Department preserve the following payment mechanisms in the future managed-care program:

- Graduate Medical Education (GME) payments should remain carved out of Managed Medicaid programs, and LDH should continue to make all GME payments under the Medicaid FFS program.

- Existing rate floors should remain at prevailing FFS levels in managed Medicaid going forward.

- Plans should be required to follow established Medicaid payment policy, NCCI, etc, unless specifically negotiated.

- Plans should be prohibited from making payment policy change through Provider Manual updates absent negotiation.

Network Improvement/Care Coordination

Demonstrable access continues to be an issue within Medicaid managed care. While the plans submit reports and the Department approves networks based on those reports, in the real-world environment, issues remain with placing Medicaid enrollees in appropriate care levels. Post-acute care, behavioral health, and home health are just a few areas where plans show providers as in network, but patients are not accepted when placement is attempted. To further exacerbate the issue, LDH has not adequately enforced 8.4.3 of the existing contract relative to denials when lower level of care placement is not made available, and the plans have shifted the risk to providers, to the financial benefit of the plans. The Department must hold plans accountable for demonstrable access, as well as discharge coordination and identification of post-discharge providers. This is extremely important as the Department furthers its desire for payment reform.

Claims Processing/Adjustment/Configuration Updates

Another area of opportunity exists in the systems administration and back-office type functions, which are the responsibility of the plans.

- Claims processing errors or issues identified by providers have historically languished for long periods of time prior to completion while the plans update systems and launch claim projects. Plans should be required to complete reprocessing and/or adjustment of claims within 30 days of the issue being brought to their attention.

- On the service front, multiple calls are often required to resolve issues. Stricter requirements around one-call resolution, as well as enforcement of the requirement, should be implemented.

Eligibility

Retro-active eligibility determinations continue to present issues. Also, the plans use different standards for retro reviews in these situations. Of particular issue are patients determined to be Medicaid-eligible while still in the hospital, and the prior authorization opportunity is not achievable. Hospitals should have the ability to notify the plans within 10 days post-discharge for these determinations. For determinations by the Department that take longer, a longer standard needs to be set and enforced.

Reporting and Transparency

LDH should enhance program transparency, and reporting should be more robust and made available in a timelier manner. Meaningful information should be provided so that not only policy-makers and regulators can monitor plan performance, but providers can also utilize in their business and contracting decisions. States such as Kentucky have taken positive steps to make information widely available and in useful formats, and we encourage the Department to use successful state and public reporting mechanics that are already available.

As Louisiana is in the midst of significant change in its Medicaid program, the LHA appreciates the opportunity to provide input on improving the Medicaid managed-care program. As always, our staff stands ready to engage the Department in continued dialogue to improve this program for Louisiana's providers and residents. We look forward to working with the Department on addressing the particular points of our recommendations.

Sincerely,

Paul A. Salles
President & CEO

Cc: Whitney Martinez, Medicaid Program Manager – Provider Networks