Written Comments on the Healthy Louisiana RFP process:

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Submitted by: Louisiana Chapter of the American Academy of Pediatrics (LA-AAP)

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Type of Organization: Provider organization

Region: Statewide

A. <u>Request for input:</u> Please share recommendations on the maximum number of statewide MCOs the state should contract with for Medicaid.

No specific comment. The current MCOs have been variably responsive to the needs of pediatric patients and have little accountability for quality of care.

B. <u>Request for input:</u> Please share recommendations related to how MCOs could offer innovations to reduce program complexity, administrative burden, and unnecessary costs and to improve care and population health in partnership with providers and patients. Please share recommendations related to how the procurement could best advance evidence-based care and meet the Triple Aim.

The Triple Aim would be best served by a <u>Medical Home</u> model of care which links patients to specific providers within the MCO network. This is essential to the quality care issue. In the current system, patients can move from one provider to another provider or ER or urgent care without consequence. This thwarts the efforts to assure timely vaccination, EPSDT services, care coordination for children with complex medical needs and other core pediatric services.

Caretakers should be allowed to change PCP to a new clinic or physician at the time of services so that the physicians and patients can then establish a long-term relationship which is the optimal for patient care. In some clinics, 20-30% of patients seen each month are not linked to the provider, which means that the provider gets no “credit” for the quality of care they provide when HEDIS measures and other pay-for-performance incentives are evaluated.

ER overuse by patients should be addressed by MCO case management teams to assure that the patient knows who their assigned provider is and where their office is located. Physicians do not have time and are not paid to track these patients. Sending letters to physicians to inform them of patients’ ER utilization is not an effective way to change patients’ behavior.

A major administrative burden is the requirement for Prior Authorizations by pediatric subspecialists for medications and/or procedures that are clearly within their scope of practice. For example, Pediatric Infectious Disease physicians should not have to get a prior authorization to use linezolid or to prescribe azithromycin for more than 7 days. Similarly, an endocrinologist should not have to get prior authorization to order a growth hormone agonist when being used to test for or treat growth hormone deficiency. The burdens tax the few pediatric subspecialists that are available, making for long wait-times for the patients who need their services. Physicians are not paid for the time

required to obtain Prior Authorizations, adding to the frustration when standard-of-care procedures and medications are being prescribed.

Specific suggestions for improving quality include: payment for continuous glucose monitors for children when prescribed by an endocrinologist,

C. <u>Request for input:</u> Please offer suggestions for changes in the next Medicaid managed care procurement to enable the Department and its contracted MCOs improve and ensure enrollee ready access to covered services, especially in rural and underserved areas.

Network adequacy is one area where the current MCOs have had only marginal success. The maldistribution of subspecialists in the state (largely confined to New Orleans, Baton Rouge and Shreveport) leaves a large portion of the state without the 100-mile access to pediatric subspecialists. One of the major reasons for this is that many pediatric subspecialties are not fiscally solvent when Medicaid does not pay for consults or allow multiple initial inpatient attending physicians. As such, subspecialist consults are "discounted" by over 60%, being paid the same as general pediatricians for complex specialty care. Without parity with Medicare regarding inpatient consultations, Louisiana's children will continue to lose access to subspecialty care, even in larger urban centers.

D. <u>Request for input:</u> Please suggest ways in which successful bidders might demonstrate initiatives that would meet the Department's goal to improve enrollee access to primary care, and the Department's desire for increased practice transformation into medical homes.

Telemedicine can be a very useful modality as an adjunct to primary care when subspecialty consultation is considered. Many subspecialists provide phone consultation to primary care doctors across the state without remuneration. This is part of quality care, as patients and PCPs receive timely input from subspecialists, guiding their evaluations and providing reassurance without delay. However, subspecialists are the ones who lose, as there is no remuneration for such services. Telemedicine provides one venue for improving quality in this area and especially in the realm of behavioral medicine and psychiatry. The shortage of mental health providers for children is worsening and is expected to continue until innovations can be made that improve access. Telemedicine is one such innovation that must be coordinated by the MCOs through a common technology that is easily accessible to providers and patients. Their investment will save money in the long run and improve care for children.

E. <u>Request for input:</u> Please offer suggestions for key aspects of behavioral health and physical health integration and how the Department 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 the Department encourage or require MCOs to employ to better meet enrollees' behavioral health needs?

Coordination of care for children with complex medical needs and for behavioral medicine MUST improve. Too many children fall through the cracks and end up in unnecessarily critical situations every day. Several approaches would be beneficial to improving coordination of care:

1. MCOs should pay for and participate in Care Coordination conferences of medically fragile children and children with complex medical needs (e.g., former preemies, children who require long-term IV antibiotics, etc.).

F.

2. CPT codes exist for care coordination by physicians and under physician supervision. These should be added to the Medicaid fee schedule so that physicians can lead care coordination activities for their patients. This includes multi-disciplinary teams and individual providers.

3. Transportation services MUST improve for children with complex medical needs and for those who lack transportation locally. Some patients travel 3-4 hours to see subspecialists multiple times each year. A recent patient had to re-schedule a trip from Lake Providence to Shreveport because the transportation service refused to change the address of the appointment to a site just one mile from the original appointment. This is unacceptable. In many states, MCOs are contracting with Uber and Lyft to provide transportation at significant savings to their bottom line and much greater compliance by the patients. This strategy should be considered as an innovation in Louisiana.

F. <u>Request for Input:</u> 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.

VBP and ACOs are far from the minds of many (probably most) physicians in Louisiana. Without a thorough understanding of how these models will incentivize quality, many physicians will push-back, as these are seen as methods to reduce reimbursement while increasing workload. Given the already low reimbursement by Medicaid compared to commercial insurance plans (approximately 60-70 cents on the dollar at best), such plans risk a mass exodus of providers from Medicaid, further driving quality down. Any attempt at cost savings should require that the majority of (if not all) savings go back to providers, not to MCOs.

G. 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?

MCOs must be held accountable for quality of care at the population level and they should be incentivized to do so. This is critical to the control of STIs, where Louisiana ranks number one or two nationally for rates of syphilis, gonorrhea, chlamydia and other infectious diseases. The scourge of these disease on our population of adolescents and young adults is unacceptable. Similarly, the impact of gun violence (Louisiana ranks number one for pediatric firearm-related deaths) and the opioid addiction crisis must be addressed at the population level by the MCOs. Coalitions of physician leaders should be brought together to work with the MCOs to address these problems. Perhaps a portion of their profit margin could be directly related to public health effectiveness on such issues.

H. <u>Request for input:</u> Please offer suggestions for the RFP and/or model contract functions and elements related to improving care management and coordination at both the MCO and provider levels. In addition, please 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? Please elaborate.

See section E above.

I. <u>Request for input:</u> 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.

See Section G above. Additionally, STIs have a much higher incidence in African-American populations. Targeted approaches to engage the African-American communities in our state, in coordination with academic medical centers and schools of public health, should be explored by the MCOs. Such community engagement should be part of their mandate, not for press attention, but for the future of our state. MCOs should be held to a more altruistic standard, as opposed to a profit motive.

J. <u>Request for input:</u> 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.

This is a particularly tough area in pediatrics, as the incentive usually is for parents to bring children to well-child visits and to address complex medical issues such as obesity by family behavior change. A key to success is the Medical Home, where parents have a personal relationship with a provider. This promotes trust, reduces ER utilization, improves vaccination rates and medication compliance, oral health and mental health. Incentivizing the use of the Medical Home, as opposed to ERs and Urgent Care clinics, is one way to promote healthy lifestyles.

K. <u>Request for input:</u> 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. Please indicate whether specific comments apply to value-added benefits for enrollees, providers, or both.

This is a complex area. In general patient incentives should be meaningful in the context of a healthy lifestyle. For example, an incentive for attendance at pregnancy-related visits to the obstetrician might include diapers or other developmentally-focused infant toys. The current list of value-added features is fairly reasonable, but there should be more focus on Weight Management, smoking cessation, Wellness screenings and well-child visits to reflect the importance of these areas for the health of our citizens.

L. <u>Request for input:</u> Please offer specific ideas for achieving the Department's aim for greater administrative simplification in its Medicaid managed care program by reducing the burden and complexity of the program for enrollees. In addition, the Department is interested in ideas to make the program less burdensome for providers by reducing paperwork, redundancies, and improving clarity of clinical criteria.

See Section B, paragraph 4 above.