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Rebekah Gee, Secretary
Louisiana Department of Health
629 N. 4th Street
Baton Rouge, LA 70802

Submitted electronically to healthy@la.gov

Re: Request for Feedback, White Paper on Advancing Medicaid Managed Care and Paving the Way to a Healthier Louisiana

Dear Secretary Gee:

Planned Parenthood Gulf Coast (Planned Parenthood) is pleased to submit these comments to the Louisiana Department of Health (LDH) in response to its Request for Feedback on the White Paper on Advancing Medicaid Managed Care and Paving the Way to a Healthier Louisiana (White Paper). As a trusted women's health care provider and advocate with two health centers in Louisiana, Planned Parenthood applauds the state's commitment to hearing from stakeholders on the significant steps being taken to transform Medicaid. For over thirty years in Louisiana, Planned Parenthood's health centers have been open to all and have become an essential part of the health care safety net in the state, playing a vital role in Louisiana's health care delivery system. In calendar year 2017, PPGC saw 12,494 patients for a total of 20,458 visits. Of those patients, 52 percent paid for services through Medicaid.

Medicaid is a women's health program, critical to meet the health needs of low-income women of reproductive age. Women comprise 60 percent of Medicaid enrollment in Louisiana,[1] and Medicaid covers 65 percent of births in the state.[2] For nearly all women giving birth, Medicaid is the source of coverage for essential health care, including prenatal and delivery care. Due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population; 30 percent of African-American women and 24 percent of Hispanic women are enrolled in Medicaid, compared to only 14 percent of white women.[3]

We support LDH's guiding principle of pursuing the Triple Aim of better care, better health, and lower costs. The next Medicaid managed care contract procurement, in particular, provides a significant opportunity to implement new and better ways to help women of reproductive age

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[1] Kaiser Family Foundation, State Health Facts, Medicaid Enrollment by Gender, 2013 data, https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender.

[2] Kaiser Family Foundation, State Health Facts, Births Financed by Medicaid, 2015 data, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid.

[3] Center for Budget and Policy Priorities (CBPP), Medicaid Works for Women, 2017, https://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact

achieve their health goals and improve their wellbeing. We appreciate the opportunity to comment on the possible design elements for the procurement, as presented in the White Paper.

In the following comments, we encourage LDH to: 1) Focus on Health Equity and Social Determinants of Health; 2) Implement Standards to Ensure Women's Access to High-Quality Providers; 3) Invest in Telehealth Technologies That Expand Access to Reproductive Health and Other Women's Health Services; 4) Prioritize Women's Health Care Needs When Expanding Value-Based Payment and Delivery System Reform Within Managed Care; and 5) Consider Women's Access to Care When Altering Value-Added Benefits

1. ***We Support LDH's Commitment to Focusing on Health Equity and the Social Determinants of Health.***

We support LDH's plans to better collect and analyze data in order to address unmet health-related social needs that contribute to poor health outcomes.

Due to the intersection of racism, sexism, classism, xenophobia, and other systemic barriers to care, people of color in the United States are disproportionately unable to access and benefit from quality health care. People denied access to competent, affordable, accessible, and humane health care see poorer health outcomes. It is imperative for health system transformation in Louisiana to recognize that various contextual factors—such as poverty, poor housing, food insecurity, mental health issues, and substance abuse—intersect with and greatly influence health outcomes in the state and cause certain populations to be at disproportionate risk of health disparities. These same factors are barriers to accessing resources that enable and promote healthy behaviors.

We believe it is critical for the state to take an active role in ensuring that social determinants are addressed and hold plans accountable for meeting their requirements in this area. This includes efforts to identify the specific needs of diverse communities of reproductive-age women, and developing culturally competent strategies to meet these needs. In addition, it is imperative for the state to commit appropriate resources to build plan and provider capacity to address the relevant social determinants. Only through an intersectional and culturally-competent human services system, including the health care system, will all individuals be able to meaningfully access the health care and other benefits they need to thrive and prosper.

2. ***We Encourage LDH to Implement Standards to Ensure Women's Access to High-Quality Providers.***

    a. **LDH Should Require Plans to Maintain Adequate Provider Networks to Meet the Needs of Reproductive-Age Women**

We appreciate LDH's intention, as set out in the White Paper and Provider Network Companion Guide (Network Guide), to hold Medicaid managed care plans (plans) accountable for maintaining adequate networks of providers. Federal regulations require states to set standards for network adequacy, including time and distance standards for certain provider types,

including OB/GYNs and primary care providers.[1] In addition, plans must demonstrate that their networks include "sufficient family planning providers to ensure timely access to covered services."[2]

We encourage LDH to prioritize strong contract provisions to ensure that plans contract with sufficient numbers of women's health care providers, including essential community providers. Many women rely on providers that specialize in women's health for their primary and preventive care needs. In fact, six in ten women who access care from women's health centers that serve low-income women consider it their main source of care, and four in ten women consider these providers their only source of care.[3]

Strong network adequacy standards are necessary to protect women's timely access to providers that specialize in women's primary health care, including family planning, women's preventive services, and pregnancy-related care. Currently, LDH standards for urban areas permit longer distances (15 miles versus 10) and wait times (30 minutes versus 20 minutes) to access OB/GYNs compared to primary care providers.

We believe that plans should be held to access standards for OB/GYNs on par with those for primary care, to ensure that networks have sufficient numbers of reproductive health care providers. Limited networks of OB/GYN providers could significantly impact access to basic health care, as well as to care that can meet women's unique health needs.

Beyond the existing types of standards, LDH should hold plans accountable for additional metrics and criteria, including but not limited to availability of providers accepting new patients and availability of providers offering the full range of family planning and related services on-site, without requiring a referral. Consideration of these factors as part of network adequacy review will help ensure that plan networks meet the needs of enrollees and provide timely access to covered services.

In addition, managed care contract requirements should align with the federal requirement that plans provide direct access to providers that specialize in women's health services, to ensure that individuals have access to all services, including women's preventive services, without unreasonable delay. [4]

b. LDH Should Require Plans to Contract with Providers That Have Language and Cultural Competence to Meet the Needs of All Women

Federal Medicaid regulations for managed care require that services are delivered in a "culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual

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[1] 42 CFR §438.68.

[2] 42 CFR §438.206.

[3] Guttmacher Institute. Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs. (Nov. 2012). http://www.guttmacher.org/pubs/journals/j.whi.2012.09.002.pdf.

[4] 42 CFR §438.206.

orientation or gender identity."[5] However, neither the White Paper nor Network Guide discusses standards relating to cultural competency and language access.

Louisiana has a population that is very diverse, for instance, in race, ethnicity, language, and culture. For many patients, decisions about family planning care are personal and intimate. Language and culture barriers are particularly difficult to overcome in the context of reproductive health care and play an important role in the experiences of low-income women, LGBTQ communities, women of color, and young people. For example, according to the U.S. Census Bureau, 8.7 percent of people in Louisiana speak a language other than English at home. More than 16 percent say they do not speak English or do not speak English well.[6] When health care professionals are aware of and sensitive to cultural and linguistic needs, they are more likely to succeed in improving the reproductive health of the populations they serve. Therefore, we recommend that LDH account for enrollee diversity and ensure that managed care plans have in-network providers that engage in culturally-competent care and make language/translation services available to patients.

3. ***We Encourage LDH to Invest in Telehealth Technologies That Expand Access to Reproductive Health and Other Women's Health Services.***

We applaud the commitment to invest in telehealth in Louisiana and encourage LDH to engage plans that have demonstrated ability to implement telehealth effectively. Telehealth is seen as a way to expand access to primary and preventive care and reduce disparities in underserved areas. In 2010, nearly half of counties nationally lacked an OB/GYN, translating into 10.1 million patients who did not have access to basic health care in their home counties.[7] Women living in underserved areas often face multiple barriers, such as lack of transportation and difficulty leaving children and jobs to travel to receive health care. Nearly half of all women of reproductive age (27 million) live in underserved areas. Women of color are disproportionately represented in this group, facing additional burdens and barriers of racism in the health care system.

We urge LDH to adopt specific policies and priorities for plans that will truly expand access for Medicaid enrollees. Contract provisions should incentivize plans not only to cover a range of telehealth services and modalities, but also support broad provider capacity to deliver care by telehealth.

First, LDH should cover asynchronous modalities allowed by state laws. Asynchronous, or "store and forward," modalities have become accepted ways to facilitate patient-provider interaction over distances. Unlike video, which requires patients and providers to be available at the same time, store-and-forward technology is patient-centered, allowing access to care at any time and place with internet service. Such flexibility is particularly helpful to deliver care to women of reproductive age who may be working or caregiving during typical provider hours.

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[5] 42 CFR §438.206(c)(2).

[6] U.S. Census Bureau. Language Use in the United States: 2011. https://www.census.gov/prod/2013pubs/acs-22.pdf

[7] American College of Obstetricians and Gynecologists, Health Disparities in Rural Women, Committee Opinion No. 586 (February 2014).

In addition, we urge LDH to incorporate contract provisions that explicitly include OB/GYN providers among possible telehealth providers. This is especially important to ensure women's access to health care in areas that do not have OB/GYNs.

Expanding coverage of telehealth services will not be sufficient to expand access unless providers are adequately paid and supported to build and sustain telehealth infrastructure. To that end, we strongly urge requirements for plans to reimburse all telehealth services at the same rate as in-person rates for identical services. In addition, when covered clinical care is provided at both originating and remote sites, providers at both locations should be eligible for reimbursement. Originating provider sites should be paid site fees at a minimum. These policies are necessary to encourage providers to offer telehealth. Accordingly, LDH should dedicate the necessary resources to support expansion of telehealth through its managed care contracts.

4. *We Encourage LDH to Prioritize Women's Health Care Needs When Expanding Value-Based Payment and Delivery System Reform Within Managed Care.*

The White Paper indicates LDH's intention to expand value-based payment (VBP) in Medicaid through the managed care program. We strongly urge LDH to prioritize reproductive health in its approach to VBP in managed care. Given the significant role Medicaid plays for women, quality and value of women's care are integral to the health and cost outcomes that the state aims to achieve with VBP.

We believe VBP can be an important way to test and implement innovative approaches, and the next managed care procurement provides a unique opportunity to promote high-value reproductive health care. Examples of reproductive health care priorities that LDH could advance through Medicaid managed care contracting are 1) improved access to preventive services, including birth control and screenings for cancer, STIs and HIV; 2) reductions in unintended pregnancies; and 3) improved maternal and infant outcomes. Making progress on goals such as these would result in better patient outcomes, as well as health care cost avoidances for the state.

a. LDH Should Ensure Participation of Reproductive Health Providers in VBP Programs.

To achieve reproductive health priorities through VBP in managed care, it is necessary to ensure that reproductive health providers can participate in innovative payment programs. One important step is to require plans to recognize the value of reproductive health providers as primary providers for reproductive-age women. Many women have their primary health care needs met at reproductive health centers, where they can access a range of preventive, screening, and treatment services that meet their needs, in addition to family planning services. Research shows that women of reproductive age say the services they needed most in the last two years were a well woman exam, pap tests, and birth control.[8] They are also more likely to report needing testing and treatment for STIs.[9] The promises of VBP to achieve better care,

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[8] Perry Undem, Women and OB/GYN Providers, November 2013 https://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

[9] Perry Undem, Examining the Health Care Needs and Preferences Of Women Ages 18 to 44, July 2017 https://www.plannedparenthood.org/uploads/filer_public/31/28/312868ed-0dcf-48a2-b146-03087fccff02/perryundem_research_july_2017.pdf.

better health and lower costs can only be realized if women's trusted, preferred providers are able to participate in VBP arrangements**.**

b. LDH Should Encourage Plans to Implement Payment Models and VBP Programs Appropriate for Small Providers.

LDH should consider the role of small providers when designing VBP programs. The White Paper references the Alternative Payment Model Framework (APM Framework) developed by the Health Care Payment Learning and Action Network (HCP-LAN). LDH is specifically looking to the APM Framework as a guide to implementing VBP through integrated, provider-based Accountable Care Organizations (ACOs). Under the APM Framework, payments to ACOs generally have a risk component tied to financial benchmarks.[10] However, the HCP-LAN does not envision that all VBPs should be risk-based. The fact is that smaller high-value providers, including providers of preventive care, may not be positioned for VBP roles, such as ACOs. The HCP-LAN acknowledges this and clarifies that fee-for-service payment with additional incentives, based on quality and performance, are appropriate VBPs in certain situations.

We believe the LDH should promote all appropriate types of VBP, consistent with the APM Framework, especially to ensure participation of smaller reproductive health care providers. Therefore, we recommend that managed care plans be given flexibility and incentives to implement various VBP arrangements, and not be limited to developing ACOs.

In addition, LDH should work with plans to develop and scale VBP programs that specifically account for the capacities of small providers. For example, small providers already bear significant burdens meeting plan reporting requirements, which are often complicated and differ from plan to plan. VBP programs should not carry additional burdens of data collection and reporting, which would be a disincentive for small providers to participate. To the contrary, we believe payment reform offers LDH a unique opportunity to promote innovation that includes all providers, for instance, by streamlining and standardizing reporting requirements across plans.

c. LDH Should Adopt Quality Measures for Reproductive Health.

Finally, we recommend that LDH adopt a robust set of measures of reproductive health care quality, including rates of chlamydia screening, cervical cancer screening, HPV vaccination, and screening for BMI and tobacco use, as well as patient experience measures. The Centers for Medicare and Medicaid Services (CMS) has approved a number of such measures in its Core Sets of measures for adults and children.[11] We believe plans should be required to report on these measures at a minimum. In addition, many of these measures are appropriate for use in VBP arrangements.

5. We Encourage LDH to Consider Women's Access to Care When Altering Value-Added Benefits.

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[10] Health Care Payment Learning and Action Network, APM Framework Refreshed for 2017, July 2017, https://hcp-lan.org/groups/apm-refresh-white-paper/.

[11] Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, Quality of Care Performance Measurement, https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/index.html.

As part of the next procurement, LDH intends to restrict the number and type of value-added benefits that plans can offer. In approaching changes to value-added benefits, we encourage LDH to focus on incentives and enhancements that do not have the effect of limiting access care.

The White Paper directs readers to a website displaying each plan's current value-added benefits. According to this information, most plans now also offer benefits such as wellness screenings, pregnancy-related care, and social media and mobile app tools, which are especially valuable to women of reproductive age. As it considers changes to value-added benefits, LDH should not restrict women's access to such plan offerings, as they enhance women's benefits overall at no additional cost to the program. At the same time, benefit offerings that incentivize women to choose among plans and providers should also provide sufficient information about clinical quality, patient experience, and cultural competence, in order for women to assess those choices. Accordingly, we urge LDH to focus on these qualitative aspects of value-added benefits, rather than the number of benefits plans may offer.

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Thank you for the opportunity to comment on the White Paper and proposals for the next Medicaid managed care contract procurement. If you have any questions, please do not hesitate to contact me at (713) 831-6510.

Respectfully submitted,

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