Louisiana Medicaid Managed Care RFP Input
On Behalf Of: Louisiana AAP
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Greetings

In response to the recent bulletin stating that LDH is seeking online input on key elements of the Medicaid managed care contracts, prior to releasing the RFP in 2021, please see the following feedback on behalf of the Louisiana AAP(LA AAP). LA AAP is dedicated to increasing involvement of pediatricians in informing policy making to positively influence the quality of pediatric practice and the welfare of children in Louisiana.

Behavioral health integration - Louisiana Medicaid seeks to integrate financing models by contracting with MCOs that manage all physical and behavioral health services for Medicaid enrollees to decrease fragmentation of care, improve health outcomes, and reduce costs. Goals of integration include enhancing provider access to data, incentives, and tools to deliver integrated services and coordinate care across settings.

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?

Feedback: *Behavioral health care IS mainstream pediatrics. Primary care clinicians, if trained and supported, are ideally positioned to identify children with mental health problems, to triage for emergencies, to initiate care, and to collaborate with MH/SA specialists in facilitating a higher level of care when needed. The AAP urges primary care clinicians to expand their comfort and skills in diagnosing and managing (or co-managing) children with common disorders including, at a minimum, ADHD, anxiety disorders, depression, and substance abuse. Louisiana AAP supports MCO reimbursement of developmental screenings. We additionally support the continuation of telemedicine for these services.*

The AAP recognizes that many of those children who are served in the MH or SA specialty system—particularly those with severe and persistent mental illness requiring intensive levels of care—lose contact with their pediatric medical home. The AAP urges that primary care clinicians and MCOs make efforts to engage these children and their families in the full range of primary care services and engage their MH/SA providers and other community partners (eg, schools, child care and Early Intervention providers, juvenile justice system, social services) in one collaborative, family-centered system of care that transects traditional silos.

LA AAP recommends MCOs facilitate a pilot of a state pediatric outpatient learning collaborative focused on increasing behavioral health services within the pediatric medical home. The model has a designated behavioral health specialist who works with practices across the state to improve behavioral health services. Strategies include colocation, links, screening for children at risk, changes in practice attitudes regarding mental health, resource development, skills development and decision making support. The AAP's mental health competencies and the mental health toolkit are used as the basis for change.

Child and maternal health outcome improvement – Louisiana Medicaid provides health insurance for more than half of all pregnancies and more than three-quarters of all children in the State. The aim of the Medicaid managed care program is to improve child and maternal health outcomes.

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.)

Feedback: *LA AAP recommends the MCOs establish and strengthen statewide, cross-agency task forces to evaluate the circumstances, causes, and missed opportunities for intervention for each maternal and infant death in order to improve care and reduce mortality. These task forces work best when they include health care providers, hospitals, public health agencies, community organizations, and families impacted by maternal and infant mortality and complications.*

One MCO opportunity would be to directly engage and support mothers by providing a dedicated information helpline and mobile app for pregnancy related resources.

MCOs would reduce adversity and build resilience by promoting screening for and addressing environmental and toxic stress and providing early interventions in families.

MCOs should promote an increase identification of and treatment for pregnancy related depression and infant social and emotional development by providing services to mothers and infants, offering training resources for health, human services and educational professionals and creating incentives to improve access and quality of care by health care providers.

MCOs should support new parents through home visiting programs such as Healthy Families America, Nurse-Family Partnership, Louisiana Parenting Education Network and Parents as Teachers, that can improve family functioning and child development, reduce health risk behaviors and child maltreatment, decrease racial/ethnic disparities, and even improve economic security.

Delivery system reform – In the last couple of years Louisiana has instituted a number of reforms related to payment models and provider network structures that will improve quality of care for Medicaid managed care enrollees. These reforms include instituting incentives such as Value Based Payments, and other incentives for quality care.

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.

Feedback: *Currently, there are a myriad of rate disparities and distortions among primary care providers for the pediatric population. One example of this would be the reimbursement of EPSDT at a Rural Health Clinic provided by clinical staff is multiples of the rate provided to a board certified pediatrician across the street in a stand-alone practice.*

VBP adoption largely depends on data access and metric functionality. An example would be determining a VBP for a pediatric practice using vaccination data points during a pandemic. This would lead to a gross misinterpretation of the quality of care being provided by that physician.

The return on investment for pediatric care varies significantly than for adult-focused care. While some short-term savings may be recognized in pediatric patients, e.g. ED utilization related to specific conditions (e.g. asthma) or utilization (e.g. inappropriate use of medication, radiologic testing). Much of the return on investment occurs over a longer life course. In addition, these cost savings may not be fully realized in the health care sector. but rather, for example, in the education sector as healthy children realize an increased ability to learn resulting in improved academic achievement and lesser need for special education, or in the workforce as healthier children lead to more productive parents/caregivers.

Additional opportunities for return on investment in pediatrics exist, such as:

- *Integrated health systems might better address adverse childhood events (ACE's) resulting in decreased chronic illness burden, including mental health issues, as children reach adulthood.*
- *Early developmental screening, including social emotional screening with appropriate follow up and intervention can limit development of expensive adolescent mental health and substance abuse issues.*
- *High rates of immunization among children save substantial dollars each year, and models should continue to promote and support high rates of immunization. Having shared accountability for a population of children and making efforts to coordinate care, to reduce duplication, and to provide timely and effective care for children will lead to a healthier cohort of adults*

An integrated pediatric health care and health-related social service delivery model should be grounded in the patient- and family-centered medical home approach to care, with a particularly strong emphasis on family engagement and family-centered care. Family-centered care has been shown to improve patient and family outcomes, increase family and professional satisfaction, decrease health care costs, and improve effective use of health care resources.

A model of care that coordinates health care and health related social services is particularly important for families of children and youth with special health care needs (CYSHCN), including the growing population of children diagnosed with mental health conditions, as they require a greater number of services, and outcomes are substantially improved when these services are integrated within primary care

For children, the social services that are "health-related" are much broader than those traditionally describe (e.g. early education and home visiting which may begin prenatally). Without embracing a broader set of social services, obtaining input from patients and families about what is important to them, and incorporating requirements and financing to facilitate the interaction between health and social services, the impact of innovative services delivery on children's health will be limited.

For VBPs or any other type of Alternative Payment Model (APM), it is vital to recognize the distinctions between pediatric and adult population health. Compared to adults, children have higher rates of poverty which influences the prevalence and severity of disease and access and response to treatment. Children have prevalent chronic conditions such as asthma, obesity, neurodevelopmental conditions, and behavioral and mental health conditions, but are generally healthier overall, with 31.6% of physician office visits in children 0-21 years of age for preventive care, while 16.8% of visits relate to chronic conditions, as opposed to 45.1% of visits for chronic condition management in adult populations. For the pediatric population, often it is not the patient but the adult parent or caregiver that strongly influences the health and well-being of children. For these reasons, the Academy believes there are inherent risks to bundling the care of adults and children into one health care delivery and financing system, and recommends that alternative payment models be implemented in pediatric-only populations, taking the unique characteristics of this group into account.

Health equity – Health Equity is defined as a state where every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential

because of social position or other socially determined circumstances. Addressing health equity in the context of Medicaid Managed Care means focusing on improving population health by working to reduce identified disparities for Medicaid populations. Quality improvement and health equity approaches will inform and guide managed care in Louisiana. This will include identifying the key social determinants of health (SDOH) and related outcome measures such as baseline health outcome measures and targets for health improvement; measures of population health status and identification of sub-populations within the population; identification of key SDOH outcomes; and strategies for targeted interventions to reduce disparities and inequities. SDOH are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors.

Please offer suggestions for how LDH can require the MCOs to focus on addressing social determinants of health and other health disparities in Louisiana. How can LDH best hold the MCOs accountable for significantly improving health equity among Medicaid managed care enrollees?

Feedback: *Examples of preventive interventions that could serve as targets for MCO impact on SDOH in the pediatric population include: (1) education efforts focused on parents, foster parents, child care providers, and preschool teachers to increase awareness of the adverse consequences of toxic stress in early childhood for lifelong outcomes in learning, behavior, and health; (2) investments in the development of creative, new strategies that can be incorporated into home-, school-, and center-based services to reduce sources of toxic stress and to strengthen the relationships that buffer children from the long-term consequences of significant adversity; (3) investments in community-based mentoring activities (eg, after-school programs, Big Brother/Big Sister, Little League, gymnastics, martial arts programs) that provide supportive relationships for vulnerable children that help them learn to cope with adversity in an adaptive manner; (4) investments in selected early-intervention programs, early-childhood mental health services, specialized family therapies, and medicolegal partnerships that have demonstrated evidence of positive impacts on vulnerable young children and families; (5) professional development programs that educate judges and other key participants in the juvenile court and foster care systems about the biology of adversity and its implications for case management, child custody, and foster care of children who have been abused or neglected; and (6) collaborative efforts with social workers, mental health providers, and other related professionals to address urgent needs as early as possible and to integrate effective services for the most vulnerable children and their families.*

Increased MCO accountability – The MCO contracts specify the MCOs' responsibilities with respect to the Medicaid managed care program. Holding the MCOs accountable for meeting the terms of the MCO contracts are important to the efficient operation of the Medicaid managed care program and ensure quality care is delivered to Medicaid managed care enrollees. While penalty provisions such as significant fines are included in the existing MCO contracts, LDH is interested in enhancing MCO accountability.

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

Feedback: *Louisiana AAP urges that LDH award fewer MCO contracts to allow for more focused quality initiatives and plan oversight. Chapter leadership understands how vital long term planning, communication and partnership is with LDH and the MCOs. We request that*

LDH leadership to the extent possible, assist in facilitating mandatory stakeholder feedback calls with each MCO and the various physician-led coalitions. This would provide a regular opportunity for LDH and the MCOs to become aware of areas where responsibilities are not being met and patient care is a concern. Louisiana AAP also urges LDH to setup and advertise a phone number and/or website where providers can provide feedback for MCO-related issues.