

Louisiana Commission on Perinatal Care and Prevention of Infant Mortality

*A Review of Priorities and Progress: SFY 2019-2020
Forecast: SFY 2021*

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Executive Summary

This report introduces and highlights the work of the Commission on Perinatal Care and Prevention of Infant Mortality (herein referred to as the Perinatal Commission, or Commission) for State Fiscal Years (SFY) 2019-2020. Established in 1989 by Louisiana statute, the 16-member governor and legislatively appointed Commission works in part, to research and review all state regulations, guidelines, policies, and procedures that impact perinatal care and, as appropriate, make recommendations to the secretary of the Louisiana Department of Health and the legislature.

This report provides information on initiatives authorized by the Commission that focus on reducing maternal and infant deaths, including the Louisiana Perinatal Quality Collaborative (LaPQC) and the Pregnancy Associated Mortality Review (PAMR). Legislative and policy priorities considered by the Commission are also identified in the report. One highlight is that legislation was passed in 2019 that authorizes the Louisiana Department of Health to promulgate and publish rules and regulations for the licensing of free-standing birth centers. This legislative action was the result of the Commission's review, deliberation and recommendation and is an important complement to overall efforts to continue to strengthen the systems of care for pregnant women in the state. In addition, the Commission informed other legislation and legislative studies that focused on addressing racial disparities in maternal outcomes including the [*Response to House Resolution 294 and Senate Resolution 240 of the 2019 Regular Legislative Session*](#), and [*Response to ACT 497 of the 2018 Regular Legislative Session*](#). Highlights of Commission subcommittee work conducted throughout the year, such as that of the Neonatal Abstinence Syndrome, Congenital Syphilis, and Membership subcommittees are included in the report as well.

Several issues and focus areas introduced in 2019 will carry over to 2020, including addressing the critical issue of disparities in maternal outcomes and safe birth outcomes.

Background

The [Commission on Perinatal Care and Prevention of Infant Mortality](#) was established in 1989 by [Louisiana Revised Statute 40:2018](#) to improve maternal and infant health outcomes in the state. The Commission is composed of 16 members, including 14 healthcare and public health providers appointed by the governor, and two members appointed by the Louisiana Legislature (see Attachment A for the statute and Attachment B for the current members and roles). Per statute, the Commission was established within the Louisiana Department of Health (LDH). Support for the Commission is provided through the LDH Office of Public Health (OPH), Bureau of Family Health (BFH) which leads the state’s public health assessment, assurance and policy functions related to maternal and child health.

The Perinatal Commission has two primary responsibilities:

- To research and review all state regulations, guidelines, policies, and procedures that impact perinatal care and, when appropriate, make recommendations to the secretary of the Louisiana Department of Health and/or the legislature
- To conduct special studies in order to inform state efforts to address maternal and infant mortality

The Commission serves as a key state-level advisory and action body working to advance policies affecting the health of women and children in Louisiana. Issues considered by the Commission are generally identified through review of key health and healthcare system indicators, practice-based experience of the membership, and special studies conducted under the authority of the Commission. Supporting the Commission is an integral part of the Bureau of Family Health’s strategies to improve maternal and infant health through system-level changes.

Foundational Strategies – OPH Bureau of Family Health



Through special studies, review of data, and elevation of policy alternatives, the Commission helps to illuminate complex health and system issues, serves as a catalyst and vehicle for aligning partnerships to advance common goals, and informs the development of solutions that can be tested and scaled within and across systems.

Priorities and Progress in SFY 2019 and 2020

Over the past two years, the work of the commission has centered around three areas of focus:

1. Support the development of policies and initiatives to prevent maternal deaths and life-threatening complications during pregnancy, labor and delivery, and post-partum
2. Continue efforts to strengthen policies related to neonatal and infant health
3. Strengthen the Commission’s ability to inform health policy and effect change

Focus Area 1. Initiatives to Improve Maternal Outcomes

The Perinatal Commission has served a critical role in efforts to address maternal outcomes in Louisiana since the time of its inception. More recently, the statutory authority and protections have allowed Louisiana to establish a model approach for bringing data to action to change policy and realize improvements within care systems. The Commission has also contributed to the advancement of other policies intended to support safe births, including requiring licensure of free-standing birthing centers and review of the maternal levels of care regulations for all birthing facilities. Over the past two years, the major areas of work have been to:

- Provide authorization and support for the review of maternal deaths through the Louisiana Pregnancy Associated Mortality Review (PAMR)
- Endorse the formation of the Louisiana Perinatal Quality Collaborative (LaPQC) and launch of improvement initiatives within the state's birthing facilities
- Evaluate regulatory requirements for birthing facilities
- Analyze other opportunities to advance maternal health and care

Provided statutory authorization and support for PAMR: The Commission has endorsed the systematic review of maternal deaths in the state since 1999. Until recently, there was not a nationally standardized approach for this important public health activity. As a result, reviews conducted under the purview of the Commission were conducted intermittently. However, the Commission's support allowed the OPH Bureau of Family Health to contribute to the development of national protocols and establish an ongoing system for monitoring and reviewing all deaths among women during or within one year of pregnancy in Louisiana. These reviews are critical for discerning causes of deaths among pregnant and postpartum women and generate tangible policy and system improvement recommendations for preventing future deaths. Medical records associated with maternal deaths are abstracted by Maternal and Child Health Coordinators within the department of health. Maternal mortality cases are reviewed by a multidisciplinary group of clinicians, advocates, and policy leaders that form the PAMR committee. In the review, the committee identifies provider, patient, and community level contributors to the maternal death. Recommendations to reduce maternal mortalities are generated based on these reviews. Those recommendations are provided to the Commission, as well as to the Louisiana Perinatal Quality Collaborative and local Maternal and Child Health Community Action and Advisory Teams. In September 2019, Louisiana was one of 25 states awarded Centers for Disease Control and Prevention (CDC) funding to support maternal mortality reviews. This funding will allow Louisiana to complete reviews within two years of the maternal death, pilot interviews with families who experienced a loss, and include committee participation from patients who survived life-threatening complications. In addition, the funding will allow Louisiana to pilot approaches to trauma informed care. The [*Louisiana Maternal Mortality Review Report*](#) was published in August 2018, in response to national and local concern regarding rising maternal mortality rates. The report summarizes findings and recommendations from a review of deaths that occurred between 2011-2016 among women who died within 42 days of the end of a pregnancy from a cause that was aggravated by the pregnancy or its management. In alignment with the national [*Review to Action*](#) protocols in 2018, Louisiana PAMR began reviewing all maternal deaths, defined as death occurring within one year of pregnancy including those that may not be related to clinical care. The next data brief, which will include all pregnancy-associated deaths that occurred in 2017, will be available in the summer of 2020. [*See the Partners for Family Health website for additional information about PAMR.*](#)

Endorsed the formation and launch of the LaPQC: The LaPQC is a voluntary network of perinatal care providers, public health professionals, and patient and community advocates who work to advance equity and improve outcomes for women, families, and newborns in Louisiana. The goal of the collaborative is to transform health systems through [proven system-improvement methods](#) so that evidence-based best practices are followed for every family, every time, at every birth facility. The LaPQC was established as an activity authorized under the Perinatal Commission and is led by the OPH Bureau of Family Health. This partnership has facilitated high-level alignment of statewide efforts to improve the systems of care and has provided an enabling environment for data to be used within the collaborative for the purposes of improving care. In August 2018, the LaPQC successfully launched Louisiana's *Reducing Maternal Morbidity Initiative*, with the aims of reducing severe maternal morbidity among women who experience hemorrhage or severe hypertension and reducing the racial disparity in adverse outcomes. Hospital teams are supported by a group of expert faculty from health systems and community-based organizations around the state, and improvement coaches. The teams are provided tools to track and monitor their data. Through the LaPQC, Louisiana hospitals have worked to implement elements of the Alliance for Innovation on Maternal Health (AIM) Severe Hypertension and Obstetric Hemorrhage Patient Safety Bundles. Forty-one of the state's 52 birthing facilities have been participating, representing 92% of births each year. Many of the facility teams have demonstrated a greater understanding of proven improvement methods in their facilities and have made important process changes as a result. The initiative's [preliminary findings](#) were released near Mother's Day 2020.

Recommended new regulatory requirements for birthing facilities: One of the explicit functions of the Perinatal Commission is to review state perinatal care regulations. In 2018, the Commission reviewed the policies and guidelines for free-standing birthing centers and found that the absence of formal requirements codified in regulation was a gap in the state's maternity care system. In 2019, Representative Hilferty, the Commission's appointed member from the Louisiana House of Representatives, introduced legislation to require birthing centers to attain accreditation from a nationally-recognized body and to require licensure through LDH. LDH Health Standards will be working with the Commission to draft regulations in accordance with the new law (see also [Act 332](#) of the 2019 Regular Session of the Louisiana legislature). These new regulations will also be informed by recommendations emerging from an overall review of the Louisiana maternal levels of care. In August 2019, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal Fetal Medicine published an update of the *Obstetric Care Consensus: Levels of Maternal Care*. In response, a workgroup was formed, including representatives from the Commission, to perform a comprehensive review and revision of Louisiana's maternal levels of care to ensure they are consistent with national guidelines.

Participated in special study groups to address racial disparities in maternal outcomes: The disproportionately high rates of maternal deaths and complications among black women highlighted in national media and in the Louisiana PAMR data prompted legislation in Louisiana calling for various convenings to generate recommendations to address these inequities. [House Bill \(HB\) 818 \(Act 497\)](#) of the 2018 Regular Session of the Louisiana Legislature established the *Healthy Moms, Healthy Babies Advisory Council* to address racial and ethnic disparities in maternal health outcomes and incorporate a community-engaged, equity-focused lens into current programs and campaigns which seek to prevent maternal mortality and severe maternal morbidity. Additionally, [House Resolution \(HR\) 294](#) of the 2019 Regular Session called for two summits to "take immediate action to address racial disparity in maternal and child health outcomes and the alarming rate of mortality for Black infants and mothers in Louisiana." Perinatal Commission members have been represented in these groups and have contributed to the recommendations published in the convenings' reports including [the report](#) from the

Health Mothers Healthy Babies Advisory Council issued in March 2020, the recommendations from the *Maternal Mortality Summit* organized by LDH in August 2019, and the findings from the *Infant Mortality Summit* organized by the Louisiana March of Dimes in November 2019. [See report here](#). While the reports reflect a broad array of stakeholder perspectives, some recommendations, such as aligning Louisiana levels of maternal care with national guidelines, requiring Medicaid to reimburse for services for women up to 12 months postpartum, and requiring participation in quality improvement initiatives for all birthing facilities, are consistent with work being undertaken by the Commission. All report recommendations are currently under review by the Commission members.

Focus Area 2. Initiatives to Improve Neonatal and Infant Outcomes

Three historical areas of attention related to neonatal and infant outcomes have included the prevention of complications for newborns associated with maternal substance use including opioids, the advancement of policies related to breastfeeding and breast milk, and the prevention of premature births. This aligns with the Commission's goals to reduce the infant mortality rate and the number of babies born with low birth weight. Over the past two years, the Commission's work has included:

- Analysis of the evolving policy landscape related to the prevention and treatment of Neonatal Opioid Withdrawal Syndrome (NOWS) and support for a legislatively mandated pilot of NOWS management in birthing hospitals
- Monitoring issues related to a medication to prevent premature birth
- Monitoring policy developments related to donor breast milk
- Monitoring and informing public health efforts to eliminate congenital syphilis
- Recommending changes to the state newborn screening policies

Analyzed policy recommendations related to the prevention and treatment of NOWS: In 2016, the Perinatal Commission completed a special study to review state policies and nationally-recommended best practices for the care and treatment during pregnancy for mothers with opioid-related substance use disorders and for substance exposed newborns. In its [report submitted to the Louisiana legislature](#), the Commission issued recommendations including coverage and benefits changes for screening and treatment, expanded treatment options and practitioners, dissemination of tools to support clinical providers, and policies to support healthy attachment and safe parenting. In 2019, a subcommittee of the Commission reviewed the 2016 recommendations and the status of their implementation. The review illuminated limited progress in the implementation of the recommendations (see Attachment C for a summary of findings and recommended actions). The expansion of Medicaid has created a more favorable environment for many of the recommendations related to covered populations and benefits. In addition, Louisiana has been awarded new federal grants that support expanded public health monitoring related to opioids and other efforts to improve screening, treatment, and prevention. The Commission's work has served as a well-defined policy agenda to inform the plans related to these important state and federal investments, and as such aligns with the Commissions' charges.

Informed the development of a pilot to improve the care of infants with NOWS: [Act 174 of the 2018 Regular Session](#) of the Louisiana Legislature called for LDH to pilot a multi-disciplinary evidence-based care approach to treat infants with NOWS together with their mothers outside of intensive care units in existing community or hospital settings. The Commission members provided guidance with the approach to the pilot, which is expected to inform the development of a formal statewide quality improvement initiative through the LaPQC in 2021.

Monitored and informed public health efforts to eliminate congenital syphilis: In 2018, LDH launched a syphilis elimination campaign. The Commission reviewed data presented by the Office of Public Health Sexually Transmitted Disease (STD) Program and provided input on the anticipated strategies to eliminate mother-to-child transmission. The Commission members provided guidance on efforts to educate providers regarding third trimester testing and treatment protocols; facilitated a stronger connection between the initiative and the Louisiana Medicaid program to address screening and treatment issues; and illuminated considerations related to their proposal to track congenital syphilis as a quality measure for the Medicaid managed care organization contracts. The Commission will continue to monitor trends in transmission and inform the prevention strategies, as needed.

Reviewed the implementation of changes in the state's newborn screening panel, prompting process improvements: In Louisiana, addition of conditions to the state's newborn genetic screening panel requires a change in Louisiana Administrative Rules and is generally subject to specific appropriation by the legislature. With the state's panel prescribed in rule, conditions historically have not been considered for inclusion until prompted by legislative action. In the course of the Commission's review of a 2019 [study resolution](#) related to adding mucopolysaccharidosis type I and Pompe disease to the state's newborn screening panel, the Commissioners reviewed the steps currently required to implement changes in the newborn screening system. The historical approach of deferring to legislative action to prompt review of new conditions contributed to a significant time delay between a condition being included in the national [Recommended Uniform Screening Panel \(RUSP\)](#) and when it is adopted for inclusion in Louisiana's panel. The Perinatal Commission's inquiry into this process helped illuminate the opportunity to redevelop the state's Newborn Screening Advisory panel and to modify the timing and the cost and feasibility assessments that are needed to inform potential implementation. In SFY 20, the OPH Genetics Program broadened the membership of the state Newborn Screening Advisory Panel and redeveloped the procedures so that any condition recommended by the RUSP will promptly trigger an evaluation of the state's capacity to implement and the anticipated financial support needed to include that particular condition on Louisiana's screening panel

Focus Area 3. Strengthen the Commission to Effect Change in Louisiana's Systems of Care

Boards and commissions are an important component of state systems to ensure the public's voice is part of governmental decision-making and oversight functions. As subject matter experts and practitioners, Commission members help ensure public policy is grounded in sound evidence and practical experienced perspective. Commission members are also change-agent champions who are vital to aligning efforts to understand and solve complex problems. To that end, over the past two years, members and supporting OPH Bureau of Family Health staff have worked to strengthen the core processes and operations of the Commission. Improvements have included:

- Definition of pathways to introduce and act on issues that come to the Commission
- Integration of supporting tools into routine operations to facilitate/enhance/streamline Commission activities
- Identification of membership and quorum challenges impacting the Commission's functions

Established decision-making pathways to support clear action on issues: The charge of the Commission is to address maternal and infant mortality. However, many of the drivers of these issues are complex and entrenched in the policies and practices across sectors. A challenge of the Commission, and that of similar boards, is to understand aspects of these problems that can be changed through the tools and authorities that are within the scope of the body. Further, with the Commission membership consisting of subject matter expert practitioners who serve in a part-time voluntary capacity, expeditious progress

requires clear deliberation and decision-making processes. In SFY 19, Commission staff and select stakeholders documented a workflow and decision-making process (Attachment D). As a result of this change, the Commission was able to make significant contributions to both legislation and policy related to maternal and child health as described in the preceding sections. Of particular note is the establishment of regulatory oversight of free-standing birthing centers, which was a recurrent topic of discussion without specific action. Once the process driver systems were put in place, the commission was able to focus on steps to advance action, resulting in legislation to create the desired regulations. In addition, the Commission provided comprehensive public comment and recommendations to LDH for consideration in the procurement of the Medicaid managed care contracts (Attachment E). The Commission is continuing to refine these important processes.

Identified structural challenges affecting the Commission's ability to conduct business: A particular challenge to the Commission carrying out its charge has been attaining a quorum at the regularly scheduled in-person meetings, thereby interfering with the ability to vote and move substantive issues forward to resolution as a formal Commission action. A membership subcommittee was formed and identified two interrelated drivers: the ability of statewide members to attend meetings and the legal requirement for in-person presence to achieve a quorum. Members who had low levels of participation were contacted to assess the feasibility of continuing to serve. The Commission worked to fill the resulting vacated seats with new representation. The subcommittee also researched laws related to meetings by public entities and other public bodies' approaches to achieving a quorum, such as through live remote technology. It was determined that a change in the Commission's authorizing statute would be required in order to redefine the body's quorum requirements. Finally, the subcommittee also explored the potential changes to the membership composition. This too would require amending existing law. Overall, the Commission has been able to coalesce a core of engaged membership and advance substantive improvements. Further structural and process improvements will be central to the Commission fully realizing its potential.

For additional information about the Perinatal Commission proceedings, approved meeting notes are posted on the [Commission's online portal](#).

Looking Ahead to SFY 2021

In SFY 21, the Commission will focus on sustaining the gains in the previous years' areas of focus and operational improvements. In addition, the Commission will seek to define and advance tangible policy and systems change improvements in areas of focus that have emerged through ongoing review of maternal and child health outcomes and health system indicators.

1. Advance policies and initiatives to improve maternal outcomes
2. Advance policies and initiatives to improve neonatal and infant health
3. Monitor and advance cross-cutting policy initiatives
4. Continue to strengthen the Commission's ability to inform health policy and effect change

To **improve maternal care and outcomes** the Commission will:

- Continue to provide enabling authorization, expertise, and leadership to advance Louisiana's approach of moving data to action for policy and systems change through **PAMR** and the **LaPQC**. In SFY 21, PAMR will pilot family interviews and the development of new data briefs to inform policy. The LaPQC will work to sustain the gains from the *Reducing Maternal Morbidity Initiative* through the development of a Safe Births designation system to recognize facilities that demonstrate ongoing application of proven improvement methods to support integration of recognized patient

safety practices, and a commitment to the provision of equitable care. In addition, Commission members will authorize the launch of the next LaPQC improvement initiative focusing on safe reduction of primary cesarean birth, in alignment with the [national AIM Initiative](#).

- Inform and monitor the implementation of [new regulations for free-standing birthing centers](#) and [maternal levels of care requirements](#) for all birthing facilities in the state.
- Develop and advance a maternal health policy agenda. Commissioners will systematically review health indicator data and recommendations from the [Healthy Moms, Healthy Babies Advisory Council](#) and the [2019 LDH Maternal Mortality Summit](#). Of particular interest is examining potential postpartum Medicaid coverage gaps. The Commission will also inform policy proposals including effective processes for birthing facilities to conduct comprehensive analysis of maternal deaths. Lastly, the Commission will review opportunities to advance the OPH Bureau of Family Health Maternal and Child Health five-year state action plan which includes an effort to advance reproductive health services and the proposed establishment of a [statewide perinatal psychiatry consultation system](#).

To [improve neonatal care and infant outcomes](#) the Commission will:

- Continue to provide statutory authorization, expertise, and leadership to support the development of a [neonatal LaPQC initiative](#) to improve the care of infants with [NOWS](#) and consider reestablishment of the [Fetal and Infant Mortality Review \(FIMR\)](#). FIMR is the state's historical process for reviewing fetal and infant deaths to understand the causes and identify opportunities for prevention. Regional FIMR review and action activities were suspended when staff was redirected to support the ascertainment of maternal deaths. In SFY 21, the Commission will consider the feasibility and efficacy of implementing FIMR as a complement to other public health monitoring activities.
- Continue to monitor and research policy issues related to 17 Alpha-hydroxyprogesterone caproate (17-P) to prevent premature birth, newborn screening, breast feeding and donor breast milk, elimination of congenital syphilis, and prevention and management of NOWS.
- Develop and advance other priorities for a neonatal and infant health policy agenda, with analytic support from the OPH Bureau of Family Health. Lastly, the Commission will review opportunities to advance the OPH Bureau of Family Health Maternal and Child Health five-year state action plan which includes an effort to establish universally offered parent coaching and support (home visiting).

To [advance cross-cutting policy initiatives](#) the Commission will:

- Work to align efforts between the Louisiana Medicaid Quality Committee and the Commission.
- Continue to research and inform issues related to Medicaid policy and develop strategies to incorporate those concepts into the Medicaid managed care program.

To [strengthen the ability of the Commission to effect change](#) the Commission will:

- Continue to improve the processes to support efficient and effective action.
- Work to address structural limitations so that the Commission can have diverse engaged representation to carry out its important charge.

Appendix

Attachment A: Louisiana Statue that Establishes the Commission

LA. R.S. 40:2018

§2018. Commission on Perinatal Care and Prevention of Infant Mortality; maternal and infant mortality studies; confidentiality; prohibited disclosure and discovery

A. There shall be established within the Louisiana Department of Health, a commission which shall be designated the "Commission on Perinatal Care and Prevention of Infant Mortality", composed of sixteen members, as provided in Subsection B of this Section.

B.(1) Fourteen members shall be appointed by the governor as follows:

(a) Two neonatologists, one of which shall be actively engaged in medical education, and one of which shall be actively engaged in private practice.

(b) One obstetrician.

(c) One family practitioner.

(d) One pediatrician.

(e) One female health nurse practitioner.

(f) One representative from a family planning clinic in the state.

(g) One neonatal nurse specialist.

(h) Two health care administrators representing the public and private sector respectively.

(i) One social worker.

(j) One nutritionist.

(k) Two perinatologists.

(2) Two members shall be appointed as follows:

(a) One member of the Louisiana House of Representatives appointed by the speaker of the House of Representatives.

(b) One member of the Senate appointed by the president of the Senate.

(3) Each appointment by the governor shall serve at his pleasure and shall be subject to Senate confirmation. The legislative members shall serve at the pleasure of the presiding officer of the respective legislative body.

C. The chairman of the Commission on Perinatal Care and Prevention of Infant Mortality shall be elected annually by the commission members and shall serve as chairman without a salary. The chairman shall report directly to the governor.

D. The commission shall hold at least six regular meetings each year at a place designated by the chairman. The commission members shall be compensated for travel in connection with the commission meetings and official commission business as approved by the chairman of the commission. Reimbursement shall be in accord with the travel regulations of the Louisiana Department of Health.

E.(1) The secretary of the Louisiana Department of Health shall assist the commission and provide any data the commission requires that is available to the state, in order to reduce the number of infant deaths and the number of unmarried, teenage pregnancies in the state of Louisiana.

(2) Reports on the status of available perinatal care and other reports as are considered appropriate based on the research shall be made to the commission.

F. The functions of the commission shall be to:

(1) Research and review all state regulations, guidelines, policies, and procedures that impact perinatal care and, when appropriate, make recommendations to the secretary of the Louisiana Department of Health.

(2) Research and review all state laws that impact perinatal care and, when appropriate, make recommendations to the legislature.

(3) Accept grants and other forms of funding to conduct maternal and infant mortality studies.

(4) Contract, in accordance with the applicable provisions of state law, for the performance of maternal and infant mortality studies.

G. Within the confines of available resources, the goals of the commission shall be to strive to:

(1) Provide, through comparison of available data and research, a plan that the state of Louisiana can adopt to reduce the number of teenage pregnancies, sick infants, and infant mortalities.

(2) Propose a plan for an equitable system of financing comprehensive health and social services for indigent pregnant women and infants that incorporates the Medicaid program in the most efficient and cost-effective manner available to public and private hospitals in the state of Louisiana.

(3) Compile and analyze information on existing infant mortality education programs and make recommendations for the implementation of public policies, for proposed legislation, and for a statewide program to combat the problem of infant mortality to coordinate and improve the services of the state, local governments, private and voluntary agencies, community organizations, and schools which serve to educate high risk candidates and their families.

(4) Reduce the infant mortality rate to not more than nine deaths per one thousand live births.

(5) Reduce the number of babies born with low birth weight to not more than five percent of all live births.

(6) Reduce the infant mortality rate for each parish and for each racial or ethnic group of the population to not more than twelve deaths per one thousand live births.

(7) Educate women of child-bearing age to be able to choose food wisely and understand the hazards of smoking, alcohol, pharmaceutical products, and other drugs during pregnancy and nursing.

H. The commission shall have the right and authority to analyze any data available through any state system that may improve perinatal outcomes in Louisiana.

I.(1) Notwithstanding any other provision of law to the contrary, the commission or its agent shall be authorized access to medical and vital records in the custody of physicians, hospitals, clinics, other health care providers, and the office of public health in order that it may conduct maternal and infant mortality studies. All such medical and vital records obtained by the commission or its agent in accordance with the provisions of this Subsection, as well as the results of any maternal and infant mortality study, shall be confidential and shall not be available for subpoena, nor shall such information be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding nor shall such records be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(2) Nothing in this Subsection shall prohibit the publishing by the commission of statistical compilations relating to maternal and infant mortality which do not identify individual cases or individual physicians, hospitals, clinics, or other health care providers.

Acts 1989, No. 352, §2; Acts 1991, No. 515, §1; Acts 1992, No. 326, §1.

Attachment B: Perinatal Commission Members and Roles

LOUISIANA COMMISSION ON PERINATAL CARE AND PREVENTION OF INFANT MORTALITY Member Roster: May 2020	
Member	Role
Dr. Perry Scott Barrilleaux, Chair	Perinatologist
Dr. Steven Spedale, Co-Chair	Neonatologist
Sen. Regina Ashford Barrow	Member of Louisiana Senate
Rep. Rhonda Butler	Member of House of Representatives
Dr. Amarjit S. Nijjar	Neonatologist
Dr. Marshall St. Amant	Obstetrician
Dr. Robert Paul Blereau	Family Practitioner
Dr. Tina Stefanski	Family Planning Clinic Representative
Vacant	Neonatal Nurse
Amy Zapata	Health Care Administrator (public)
Dr. Rodney Wise	Health Care Administrator (private sector)
Emily Stevens	Social Worker
Leslie Lewis	Nutritionist
Dr. Joseph Biggio	Perinatologist
Vacant	Pediatrician
Vacant	Nurse Practitioner in Women's Health
Karis Schoellmann	Staff Support, Bureau of Family Health

Attachment C: Status of Recommendations from Response to HCR No. 162

Louisiana Commission on Perinatal Care and Prevention of Infant Mortality

Response to House Concurrent Resolution No. 162:

Prevention, Screening, and Treatment of Neonatal Abstinence Syndrome, Screening Section
Issue Brief and Recommendations: February 2019

Sub Committee: Dr. Drury, Dr. Stefanski, Emily Stevens

Supported by: Robin Gruenfeld, Karis Schoellmann

Background

House Concurrent Resolution (HCR) 162 of the 2015 Regular Session of the Louisiana Legislature directed the Commission on Perinatal Care and Prevention of Infant Mortality (Perinatal Commission) to study and make recommendations related to the prevention, screening, and treatment of NAS. This document, *Prevention, Screening, and Treatment of Neonatal Abstinence Syndrome* contains recommendations to prevent NAS through screening and care coordination for families living with substance use disorder (SUD). The five recommendations related to screening will be reviewed here, with updated information from the intervening two years, as well as recommendations for the Perinatal Commission to shepherd change.

The Issue

Adequate screening for substance use, pregnancy, and risk of unintended pregnancy are key to early identification and treatment. As part of the study, the Perinatal Commission queried a sample of birthing hospitals in the state on maternal screening, referral and treatment practices, and NAS assessment and treatment protocols. Of the 26 hospitals queried, Louisiana hospitals do not use evidence-based verbal screens to universally screen for substance use among women during pregnancy, nor do they universally perform urine drug screens on pregnant women who present to labor and delivery. Several hospitals report conducting urine drug screens upon hospital admission for pregnant women when there is a concern of potential substance use; however, opioid use is so widespread that selective screening will lead to many missed opportunities for treatment.

There are several types of SUD treatment providers in Louisiana, including Office of Behavioral Health (OBH) clinics, privately-owned methadone clinics, and office based opioid treatment programs (OBOTs). OBH manages seven clinics statewide that accept pregnant or parenting women with SUD. Those clinics are mostly abstinence-based and are residential (not in-patient). Over the last decade, funding for those clinics has dropped from \$7 million to \$3 million dollars. An additional ten privately-owned methadone clinics in Louisiana serve individuals with SUD. Program oversight for those methadone clinics is provided by OBH through the State Opioid Treatment Authority (SOTA). SOTA ensures programmatic adherence to both state and federal guidelines, and each provider is accredited by both Commission on Accreditation of Rehabilitation Facilities (CARF), SAMHSA, and JCAHO (in one case). Office Based Opioid Treatment providers (OBOTs) receive oversight from physician licensing entities and Medicaid and/or Healthy LA policies and procedures.

Status Update of Screening Recommendations from the *Prevention, Screening, and Treatment of Neonatal Abstinence Syndrome Study Resolution (2016)*

Recommendations 1 and 2: Verbal screenings for substance use be conducted in the primary care and obstetric settings. Universal screenings for substance use be conducted for reproductive age women using a validated screening tool at the time of visits with all medical providers.

- Medicaid data reflects that providers are not requesting reimbursement for screening. Additional research is required to identify drivers.
- Statewide variability among screening practices remain.

Recommendation #3: Louisiana Substance Use and Pregnancy Toolkit be made available and utilized by providers who treat families who have risk factors for NAS.

- The Louisiana Substance Use and Pregnancy Toolkit is complete. Unfortunately, resources did not provide for an evaluation component to quantify efficacy and utilization.
- The Office of Behavioral Health cited the size of the Toolkit as a barrier to providing printed copies to all obstetric practices, though they were provided to women's service providers and residential facilities. DCFS distributed them to all child and family service units and copies were shared with clinicians at a substance abuse counselor conference.
- OB/GYN clinics received a link to a website where they can access the full document.
- Several hard copies remain for dissemination at Office of Behavioral Health.
- Updates to the Toolkit could be made on the website.

Recommendation #4: Screening for Pregnancy should be conducted in the prescribing provider's office.

- CARF and SAMHSA-accredited treatment facilities are only required to conduct pregnancy screens before initiation of medically supervised withdrawal.
- SAMHSA and CARF standards require treatment providers have policies and procedures in place related to treatment and transfer of pregnant women. In other words, Office of Behavioral Health SUD treatment clinics and SOTA-administered methadone providers are not mandated to perform pregnancy screens per current regulatory guidelines (last updated Sept. 2015).
- There are no requirements that physicians screen for pregnancy before prescribing opioids to women of reproductive age.

Recommendation #5: Providers and clinics should facilitate linkage to high quality reproductive health services and offer pregnancy testing to women of reproductive age who are in their care for MAT or treatment plans that include opioids during all visits to identify pregnancy early.

- Additional research is required to determine if there are enough obstetric providers in Louisiana that feel knowledgeable, supported, and empowered to care for pregnant women with SUD.
- There are no clear efforts to ensure bidirectional access to MAT and obstetric care.
- OBH and SOTA worked with the Bureau of Family Health in 2017 to interview and compile an assessment of reproductive health in women participating in MAT programs. The goal was to identify gaps in services, provider education and technical assistance where needed. The outcomes from this project were used to educate each provider on reproductive health needs, service gaps, and best practice suggestions.
- Overall, despite the 5 screening recommendations made in the study resolution, there has been insufficient progress statewide in addressing key barriers to effective SUD treatment for pregnant women and opioid impacted mother-infant dyads. Screening practices are insufficient, collaborative care between SUD treatment facilities and obstetric care is crippled and ineffective, and resources developed to improve the care of mothers with opioid use disorders

have been inadequately distributed and implemented without any evaluation plan. When considered in combination with Louisiana's consistent and potentially climbing rates of infants born with opioid exposure, without significant changes in care practices rates of exposure and negative long term outcomes of infants with opioid exposure are not likely to improve, resulting in continued increases in treatment costs both in the perinatal period and potentially for the life of the child.

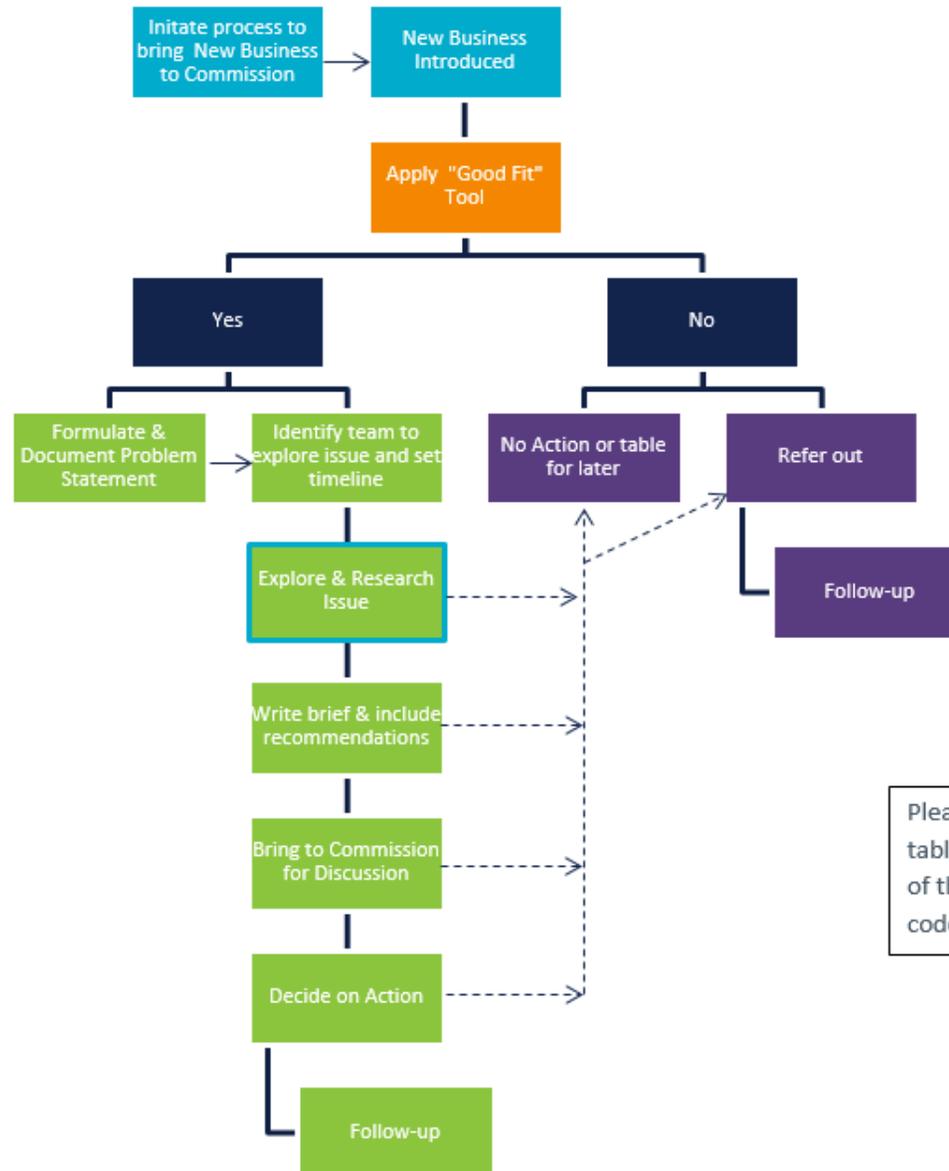
Current Recommendations to the Perinatal Commission (2019):

1. Request OBH survey OBH supported SUB treatment clinics and SOTA administered methadone providers to identify 1) what percentage are routine screening verbally or biologically for pregnancy during opioid treatment and 2) barriers facing the clinics in implementing screening measures (e.g. cost, reimbursement, patient compliance)
2. Request presentation from the Bureau of Health Informatics on current and future NAS surveillance strategies, emphasizing the utility of those data in policymaking. Data of interest to include rate of opioid prescriptions in women of reproductive age, incidence of SUD and OUD in women of reproductive age, number of women in defined cohort provided pre-conception or inter-conception counseling, pregnant women with SUD and OUD, number of prenatal visits in the defined cohort vs. number of prenatal visits in the overall population, referral to SUD treatment, referral to obstetric care, time from referral to initiation of treatment, and barriers to initiation of treatment"
3. Ensure representation of the Perinatal Commission on relevant statewide workgroups committed to resolving the opioid crisis, e.g. the HOPE Counsel. Commission representatives will advocate to:
 - Mobilize relevant stakeholders to identify barriers to SUD screening in physicians' offices,
 - Design strategies for removal of barriers to SUD screening and provision of warm referrals, between obstetric practices and SUD treatment programs including consideration of co-localized care,
 - Expand opportunities for approved continuing medical education relative to prescribing controlled substances for pregnant women
 - Expand opportunities for approved continuing medical education to provide training on the implementation and billing for evidence-based SUD screening in primary care and obstetric settings that integrate distribution of appropriate and effective referral plans.
 - Collaborate with OBH to develop and implement rule changes that would require regular interval assessments of pregnancy testing in SUD treatment facilities and ensure that reimbursement barriers are addressed
 - Collaborate with OBH to ensure funding for monitoring of OBH supported SUD programs related to both effective integration of collaborative care with obstetric providers and implementation of pregnancy screening.
 - Identify opportunities and funding sources to expand the development and implementation of e access to evidence-based treatment of the mother-baby dyad, adequate communication between methadone treatment clinics and obstetric providers, and identify strategies for postpartum treatment and follow-up for MAT patients.
4. Request a presentation/report from Title X that:
 - Identifies barriers and opportunities for provision of contraception, including LARCs, for women of reproductive age who chose to avoid pregnancy during MAT, and
 - Highlights existing and planned work between the Bureau of Family Health (Title X) and other OPH programs to address the care of pregnant women and mother-newborn dyads impacted by opioid use disorders

Attachment D: Process for Introducing New Business

Louisiana Perinatal Commission Process for Introducing New Business

Feb 9, 2018



Please refer to the attached table for details about each step of the process. The table is color coded to match this flow chart.



Step 1 Initiate Process	Engage process to introduce new business to the Perinatal Commission		
	Members make request either at a Perinatal Commission Meeting or via e-mail to the chair and to assigned Commission support staff	New Business is scheduled for discussion at a Perinatal Commission meeting, and any informational support materials are sent out to members at least 2 weeks in advance of meeting.	
Step 2 Good Fit Tool	At Commission Meeting, apply questions to determine if topic is a good fit.		
	What is the problem?	Commission Responsibilities (from legislation)	Commission Goals (from legislation)
	Does it align with the charge of Commission? How? (See columns to the left, specify)	<ol style="list-style-type: none"> 1. Research and review all state regulations, guidelines, policies, and procedures that impact perinatal care and, when appropriate, make recommendations to the secretary of LDH. 2. Research and review all state laws that impact perinatal care and, when appropriate, make recommendations to the legislature. 3. Accept grants and other forms of funding to conduct maternal and infant mortality studies. 4. Contract, in accordance with the applicable provisions of state law, for the performance of maternal and infant mortality studies. 	<ol style="list-style-type: none"> 1. Provide, through comparison of available data and research, a plan that the state of Louisiana can adopt to reduce the number of teenage pregnancies, sick infants, and infant mortalities. 2. Propose a plan for an equitable system of financing comprehensive health and social services for indigent pregnant women and infants that incorporates the Medicaid program in the most efficient and cost-effective manner available to public and private hospitals in the state of Louisiana. 3. Compile and analyze information on existing infant mortality education programs and make recommendations for the implementation of public policies, for proposed legislation, and for a statewide program to combat the problem of infant mortality to coordinate and improve the services of the state, local governments, private and voluntary agencies, community organizations, and schools which serve to educate high risk candidates and their families. 4. Reduce the IMR to not more than 9/1000 5. Reduce the number of babies born with low birth weight to not more than 5% of all live births. 6. Reduce the IMR for each parish & for each racial or ethnic group of the population to not more than 12/1000. 7. Educate women of child-bearing age to be able to choose food wisely and understand the hazards of smoking, alcohol, pharmaceutical products, and other drugs during pregnancy and nursing.
	What is the priority of this issue?		
	Is there time sensitivity? What potential time commitment may be needed?		
	What Commission member should spearhead the topic?		
	If the Commission does not take on the issue what organization should?		
	Other question		

Louisiana Perinatal Commission Process for Introducing New Business

Feb 9, 2018

Step 3: Yes / No, Decision			
If decision is Yes, Go to Step 4	Options for "No"		
	No action to be taken	State the reason	
	Table for later	State the reason and project timeframe	Track and follow-up
	Refer to another agency/organization,	Examples: Medicaid Quality Committee. Perinatal Quality Collaborative, Louisiana Medicaid, March of Dimes, Other LDH Commissions, Office of Behavioral Health...	Determine and document tracking & follow-up needed.
Step 4 Commission decides to take-on issue/topic			
	Yes		
	1. Formulate and document the problem statement		
	2. Identify a team to explore issue and establish a timeline		
	3. Collect relevant data, explore & research topic & issue utilizing tools (i.e. fishbone and question templates)	<i>This needs to be flushed out- determine line of questioning to be applied to issue.</i>	
	4. Write a brief that includes recommendations and options for action		
	5. Bring to Commission for discussion and determination of action		
	6. Decide on Action	Examples of Action: Propose LDH Policy Change, engage legislature for policy, write formal letter of request to organization(s) develop position statement, write white paper.....	Utilize Robert Rules of Order for procedural voting and decision making.
	7. Implement Action & Follow-up		Determine & document tracking and follow-up needed

Attachment E: Recommendations for the Medicaid Managed Care Program

Feedback from Members of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality

Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care
http://www.Medicaid.la.gov/assets/HealthyLa/MEDICAID_MCO_RFP_WP.pdf
Due by April 17, 2018 to healthy@la.gov

1. Limit Number of Statewide MCOs

- a. With more MCOs there comes more sets of regulations, which in turn increases confusion and administrative burden for providers.
- b. Reducing the number of MCOs would in turn reduce the monitoring burden on Medicaid.
- c. Reducing the number of MCOs reduces overhead costs for the system; less CEOs, CMOs, HR efficiencies, etc.
- d. Medicaid should consider what the population health ramifications are from having multiple plans with members receiving different services and interventions.
- e. In keeping with CMS guidelines, Medicaid should consider limiting the number of plans to the minimum number allowable of two.
 - i. A structure should be put in place to ensure that there is adequate competition between health plans on both price and member care in order to maximize taxpayer resources and improve health and patient satisfaction outcomes.
- f. If the burden of multiple plans is deemed necessary, policies should be put in place to minimize the strain on providers and ensure their satisfaction with the program.

2. Expect MCOs to Operate as Innovators to Achieve the Triple Aim

- a. Strides could be made towards achieving the Triple Aim if MCOs and providers had an agreed upon consistency in clinical pathways, i.e. a standard approach to common diseases and treatments.
 - i. Add a baseline/floor for Medical Necessity
 - ii. Utilize existing clinical resources to vet clinical guidelines
 - iii. While the standard approach should be adhered to for a majority of cases, a functioning and efficient review process should be implemented which yields to the judgment of the provider in cases which deviate from the norm.
- b. Medicaid could align kick payments with desired outcomes in order to incentivize behavior from MCOs.
- c. Medicaid should reevaluate the rate structure to financially incentivize the health plans to invest in innovation and evidence based practice to work towards the Triple Aim such that the return on their investment is appealing to their shareholders.
- d. Medicaid could align quality measures with the state's population health goals and work plans. For example, collaborate with the Office of Public Health, Office of Behavioral Health, Office of Citizens with Developmental Disabilities and health initiatives led by the Office of the Governor/Children's Cabinet.
- e. In the RFP, Medicaid should require MCOs to discuss the level of evidence (emerging, promising, or best) of proposed programs and interventions they plan to offer

members. There should also be discussion if these programs are developed internally or offered by a national provider organization. Pilot projects have merit, but the applicant should discuss how they plan to move the program along the continuum of evidence.

- f. MCOs should be required to publicly report on strategies and interventions to improve population health during the course of the contract to allow community providers to play a role in achieving the Triple Aim and increase monitoring, evaluation and accountability.
- g. Medicaid should require plans to participate in Clinical Quality Improvement (CQI) initiatives that involve stakeholders, providers, and consumers to improve care and outcomes for each quality measure.
- h. Medicaid should require MCOs to contract with community providers who operate nationally recognized evidence based programs, which provide supportive services to Medicaid members known to reduce costs and improve outcomes. Programs such as Nurse-Family Partnership, Parents as Teachers, Healthy Start, and supportive pregnancy care models such as Centering Pregnancy all support the achievement of the Triple Aim and their sustainability and expansion directly benefit MCOs and their members.
- i. Provider satisfaction with the MCOs and the Medicaid program is critical to program success. Provider engagement and satisfaction needs to be more clearly incorporated into the elements of the Triple Aim in Medicaid managed care.

3. Enhance Network Adequacy and Access Standards

- a. Increase “secret shopping” in order to test networks for not only acceptability but also timeliness of access.
- b. Other indicators that support timely access include:
 - i. Wait time for appointments by provider type and diagnosis codes
 - ii. Office wait time during appointments by provider type
 - iii. Care coordination (looking at average number of patients shared between provider types is one kind of indicator of well-coordinated care)
 - iv. Well child checks (missing timely appointments is indicative of lack of access to primary care). Although the Well-Child visit is a current clinical quality measure, it is a measure that can be used across Medicaid Sections, including both Quality and the Rate Setting and Audit team, which manages transportation.
- c. Highlighting the gaps in timely access will also help inform public health needs and interventions.
- d. Medicaid should provide a system (hotline, online form, email address, etc.) for members, providers, and community supports to report patient access issues. Medicaid should then have some system in place to address these concerns and close the loop with the complainant in a timely manner.
 - i. Transportation services must be improved for low-income families seeking medical care. Access to a car or public transportation can often determine whether a child accesses healthcare. Furthermore, lack of transportation worsens access issues created by network inadequacy. Medicaid should define how often transportation reports will be analyzed for periodic changes and publicly share the results and corrective action plans for members. In addition to the use of CAHPS, the creation of local patient satisfaction surveys can help to address Medicaid transportation issues. Another alternative option would be to design a survey specifically created for and advertised to members. This survey would be used to report lack of transportation access or tardy

appointment arrival, which can cause missed appointments. These results would highlight problem areas/trends for further investigation.

- ii. Care management and other member coordination services offered by MCOs should include much clearer assistance with coordinating transportation services to help ease the burden on patients to navigate these barriers to care.
- e. Consideration needs to be made for supports for parents whose children are members but they (the parents) are not. Specifically, more support around transportation to appointments and meetings with providers would be helpful. For example, a gap may exist for parents of children who are in the NICU under current Medicaid transportation regulations as the patient is being transported; the parent's ability to travel to be with their child is critical. Addressing these issues will improve access and utilization. This could include promoting already available supports such as public transportation, MCO provided transportation, and options for family and friends reimbursement. Additionally, the department should explore opportunities for innovations such as the use of ridesharing services. Proper education needs to be provided to members around what service is appropriate when considering the urgency of the medical situation.
- f. Provide for the utilization of telehealth and telemedicine to meet network needs. These strategies should be utilized and reimbursed when appropriate.
- g. Medicaid should evaluate the process and remove barriers to MCOs reimbursing services outside or above the current fee schedule to increase member access to harder to obtain services.
- h. The burden to find accesses to care and set appointments for members should fall back to MCOs as part of their care management obligation; it is currently on the member.
- i. MCOs should engage in regular CQI projects with communities to address frequent access inadequacies engaging members, providers, and health systems to improve access and timeliness issues.
- j. If the network adequacy and access standards outlined in the contract are not being met by the health plans, Medicaid should publish their corrective action plans and results on the LDH website in an effort to provide greater transparency and improve informed decision making on the part of the member and stakeholders. MCOs may be more willing to adjust provider rates, provide greater support to those who work in rural areas, accept Medicaid patients at all practice sites, and develop creative solutions to provider shortage issues when transparency and clearer penalties for non-compliance are given more weight.
- k. Subspecialty providers should be separated out by adult and pediatric providers. Adult subspecialty providers cannot treat many pediatric problems. Pediatric neurologists and pediatric otolaryngologists, clinical geneticists, and developmental behavioral pediatricians are all essential subspecialists that are in short supply in Louisiana. In addition, there are not enough American Sign Language interpreters and auditory and verbal therapists.
- l. An access barrier exists from the lack of interpreters available by MCOs in non-hospital outpatient settings. Clinical experience from the hospital system (which works well and should be used as a model) suggests that the use of interpreters in different forms are not equally successful and strides should be made towards the highest level of service along the continuum of 1) in person, 2) then video, then 3) telephonic. Providers and members often need translation for languages such as Spanish, Vietnamese, and Korean etc.

4. Invest in Primary Care, Timely Access to Care, Telehealth and Medical Homes

- a. Provide for reimbursement for both telehealth and telemedicine.
- b. Telehealth and telemedicine are critical to meet the shortfalls in access to providers for behavioral health.
- c. A common definition for a medical home is necessary in order for all parties to understand; then implement protocols and incentivize providers to put the medical homes into practice.
- d. Parameters and possibly requiring a specific evidence based model for a Patient Centered Medical Home is necessary to ensure that the program is instituted with quality and consistency across MCOs.
- e. The contract should require MCOs to pilot contracts with primary care providers to engage in the Direct Primary Care model.
- f. To improve the effectiveness of triage lines, Medicaid contract monitors should regularly audit these triage lines for clinical effectiveness, customer service, and utilization.
- g. In addition to ensuring network adequacy for primary care, Medicaid should also include a requirement to assure utilization of primary care to improve population health and work towards the Triple Aim.

5. Improve Integration of Physical and Behavioral Health Services

- a. Reimbursing for telemedicine and telehealth and providing technical assistance and encouraging co-location could increase integration in primary care
- b. Providing reasonable reimbursement for behavioral health screening and intervention to primary care providers will incentivize the provider to increase the length of the appointment time in order to better address behavioral health needs.
- c. Many current medical homes have behavioral health providers on site, but billing rules that do not allow for multiple visits in a single day (for primary care and behavioral health) are a barrier to streamlined, integrated care.
- d. Coordination of data systems between primary care, behavioral health, and community providers (home visiting, schools, school based health clinics etc.) would reduce the multiple administrations of the same screenings and improve care coordination.
- e. Medicaid should encourage plans to look at contracting with community providers who support client's behavioral health outside a traditional clinic setting including home visiting programs and infant mental health specialists.

6. Advance Value-based Payment (VBP) and Delivery System Reform

- a. VBP and Accountable Care Organizations (ACOs) need a common definition created by Louisiana Medicaid in order to spur further conversation and innovation.
- b. VBP systems are likely difficult to implement for independent providers as they do not manage enough service lines to attend to the needs of the whole patient and may not be able to spread costs across their patient population to work within thin margins. Larger health systems may have the resources necessary to achieve the cost savings associated with VBP.
- c. VBP and ACOs are likely difficult to implement and are not as feasible with the current MCO structure which adds an additional layer of management and thus reduces margins.

- d. Medicaid should work with the healthcare community to identify pockets of possible readiness in order to offer TA and pilot VBP arrangements before rolling out a full ACO program.
- e. As systems are developed to pay for quality and outcomes leading to VBP and ACO relationships, integration with population health initiatives and existing programs of the state should be aligned in order to maximize results and system wide effects.
- f. Until proper VBP arrangements can be put in place, providers both clinical and community should be able to bill to recoup care and case management costs that they are currently providing to fill the gap left by plans. In many cases, providers are scheduling appointments, securing DME, providing case management between appointments, and advocating for clients to the MCO care and case managers. Until MCOs are able to adequately provide these services or enter into VBP arrangements, providers should be able to bill for them.

7. Promote Population Health

- a. Medicaid should utilize public health professionals to develop and implement a consistent definition of population health for both Medicaid and the MCOs to follow. For example, consult the American Public Health Association and the Institute of Medicine for a definition.
 - i. Regardless of who is responsible for providing case management and population health services there should be a common definition, standards, monitoring, evaluation, and CQI in place. These strategies and goals should be shared amongst plans to generate economies of scale.
- b. Population health does not exist in a vacuum; MCOs should be required to discuss in their response to the RFP how they will integrate with systems of care, their fellow MCOs, and initiatives of the state outside of Medicaid. During the course of the contract, MCOs should report their efforts related to this integration, which should be available publically to encourage further collaboration.
- c. The MCOs should promote and refer to population health evidence-based programs from the Office of Public Health that are designed to serve their populations, such as home visiting programs such as Nurse Family Partnership and Parents as Teachers from the Office of Public Health-Bureau of Family Health.
- d. The MCOs should use health promotion materials developed by the Office of Public Health Bureau of Family Health programs to improve health and prevent mortality, such as Give Your Baby Space to promote safe infant sleeping.
- e. Inconclusive evidence exists regarding the benefit and efficacy of health fairs and community screenings.

8. Improve Care Management/Care Coordination at MCO and Provider Levels

- a. At a minimum, Medicaid needs to re-design standards of care and set minimum expectations. The current process and implementation elicits very low participation in case management with the current group of MCOs.
- b. Define and structure Medicaid risk-stratified, tiered (e.g., basic, moderate, and intensive) levels of care coordination/case management. For example,
 - i. Define three levels of care coordination/case management in managed care contracts.
 - ii. Use children with special health care needs national screening tool to identify a group qualifying for enhanced care coordination/case management.

- iii. Use algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk among children and their families.
- c. MCOs should have to coordinate care with community-based providers.
- d. Medicaid should require MCOs to stratify members based upon their care management needs. As members require more intense levels of care management, MCOs should be required to offer that care at the highest level of evidenced based intervention available and encouraged to contract that work to established community providers to move the care closest to the patient and the local system. The care management needs include not only clinical needs, but also social supports to address the social determinants of health and be offered in an equitable manner
- e. As a part of its monitoring function, Medicaid should require MCOs to regularly and publicly report on the structure of their care and case management systems including staffing types, interventions and services offered, manager to member ratios, and utilization. MCOs should also regularly provide a summary of services and how to access them which can be shared with the public. This would make it easier for providers, other care coordination, and social support entities to coordinate with the MCOs.
- f. In the RFP, MCOs should be required to describe their strategies for care/case management and identify the staff who will be executing these functions. In their response, MCOs should describe why it is the right intervention with the right provider type for the member whether it be an MD, PA, NP, RN, LPN, Community Health Worker, or paraprofessional. MCOs should report on this throughout the duration of the contract.
- g. If Medicaid is to require the use of Community Health Workers, they should think about the required credentialing and look at the educational systems in the state to ensure that there exists enough CHW programs to meet the demand. Additional thought needs to be put into who will bear the cost of the credentialing; provider or MCO? Additionally, this would offer an opportunity for Medicaid to collaborate with the Louisiana Workforce Commission as well as higher education systems.
- h. The medical home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a health care provider to provide comprehensive and continuous medical care to patients with the goal of obtaining maximal health outcomes. MCOs should all use the same exact criteria to define high performing pediatric medical homes, select the same performance measures, and incentivize practices and clinics to deliver quality services.
- i. Characteristics of the PCMH should include:
 - i. High performance on access to care measure and high percentage of children receiving well-child visits;
 - ii. High rates of children who are up-to-date on recommended well child visits and immunizations (or a pediatric preventive services bundle);
 - iii. Screening for general development, social-emotional development, special health care needs, maternal depression, and social determinants of health, including high performance on developmental screening measure;
 - iv. Effective care coordination/case management with high rates of completed referrals;
 - v. Demonstrated family engagement, measured by satisfaction with care and use of Bright Futures pre-visit tools or Well-Visit Planner;
 - vi. High performance on measure for weight assessment and counseling;

- vii. Low rates of unnecessary emergency department utilization; and
- viii. Additional resources provided in practice (e.g., integrated mental health,
- ix. Healthy Steps, Medical-Legal Partnerships, Reach Out and Read, Project DULCE).
- x. Additional measurement and framework resource:
https://www.ahrq.gov/sites/default/files/publications/files/ccm_atlas.pdf
- j. MCOs can incentivize Medical Home transformation by:
 - i. Incentivizing NCQA certifications (or other evidence based certification programs)
 - ii. Offer meaningful Medical Home technical assistance to practices (meaningful being a technical assistance that provides orientation to the MH Model and paths to certification, suggested methods of operationalizing MH, and mentorship throughout the process from a certified consultant.
 - iii. Reimburse for care coordination codes- either for all practices or for a select few (ex: those who have designated care coordinators or LCSW's providing BH interventions.)
 - iv. Incentivize combined initiatives for Behavioral health and Medical Home. Ex: those having LCSWs provide both behavioral health interventions and care coordination services.
 - v. Recommend the use of family feedback for quality improvement. (We recommend the CAHPS Clinician and Group Patient-Centered Medical Home Survey 2.0 Found here: <https://www.ahrq.gov/cahps/surveys-guidance/cg/pcmh/index.html>.)
- k. MCOs could suggest triaging by requiring/incentivizing the use of the national Children and Youth with Special Health Care Needs screener:
<http://www.cahmi.org/projects/children-with-special-health-care-needs-screener/> and
<http://www.cahmi.org/wp-content/uploads/2014/06/CSHCNS-Fast-Facts.pdf>

9. Increase Focus on Health Equity and Social Determinants of Health

- a. Members should experience care equity. That means that regardless of plan, members should expect to receive the same baseline level of care across the board.
- b. Many members have multiple individuals coordinating their care, health plan case managers, home visitors, DCFS caseworkers, social workers, etc. Coordination between these individuals providing case management services should be encouraged to increase data sharing, decreasing duplication, and improving outcomes. The health plan may not always be the best entity to be the “hub” of a member's care coordination; in these cases the MCO should be contracting with other entities to provide these services.
- c. MCOs should look at the whole person when addressing/managing chronic diseases to identify underlying causes related to Social Determinants of Health, including mental health and wellbeing as well as trust of medical provider.
- d. MCOs must show a commitment and have concrete plans in their response to the RFP to embed an equity focus to their internal work. This could include:
 - i. Staff training on social determinants of health, particularly systemic inequity that leads to health disparities (i.e., Undoing Racism workshop, implicit (unknown) bias training, etc.)
 - ii. Utilize equity impact assessments for decision making, like this one: https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf. While it is specific to racial equity, the framework can be applied to

assess the impact on equity in other areas like class, language, ability, sexuality, etc.

iii. Staff training could apply to state Medicaid monitoring and quality staff as well.

- e. MCOs must make a focused effort to recruit, develop, and retain a diverse staff, striving to eliminate opportunities for unknown/known bias. These efforts should be described in their response to the RFP with specific goals and in turn progress should be reported to the state regularly
- f. MCOs must utilize equitable language in internal and external communications (this document might be helpful even though it is media-focused: https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf)
- g. MCOs must show a commitment and have concrete plans to engage community members in data collection, analysis, and dissemination and in key decision/planning points. They should train their staff on how to effectively and respectfully engage communities, and/or hire community/family representatives (parent liaisons, etc.)
 - i. MCOs should propose and implement (possibly as a pilot study) innovative solutions to issues related to the social determinants of health such as substandard housing, transportation, food insecurity, and community violence. Results should be publicly reported on.
- h. MCOs must establish communication/partnership with other sectors outside of the clinical setting related to health (housing, transportation, education, employment, faith-based orgs, etc.) in order to build cross-sector solutions.
- i. This resource from GARE is also really helpful in breaking down key steps to starting racial/health equity work—the language here may help inform what to ask for and look for from the MCOs: https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf
- j. Use the following tool during the RFP process to incorporate health equity as much as possible into the whole proposal and contracting process: <https://asphn.org/wp-content/uploads/2018/01/Health-Equity-Language-Checklist.pdf>
- k. ACOG recently released a Committee Opinion on the importance of social determinants of health and cultural awareness in the delivery of care. MCOs have the opportunity to support provider implementation in the delivery of care. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Importance-of-Social-Determinants-of-Health-and-Cultural-Awareness-in-the-Delivery-of-Reproductive>

10. Apply Insights from Behavioral Economics to Facilitate Enrollees’ Healthy Behaviors and Choices

- a. Incentivize behaviors backed by evidence such as reducing mortality rates and/or improving quality of life and provide incentives that help the member implement that behavior. For example, having a safe infant sleeping environment reduces infant mortality, so if someone is pregnant and goes to prenatal care, MCOs can become partners with Cribs for Kids to offer pack-and-plays, car seats, or a stroller to the parent as an incentive for another part of pregnancy care that can also reduce cost, such as adequate prenatal care.
- b. MCOs should partner with programs and agencies that provide incentives at bulk rates to the MCOs such as the Cribs For Kids example above.

- c. For equity purposes, find out what is a meaningful incentive from the population being served – conduct local and regional focus groups instead of leaving the decision up to the marketing department or national parent company.
- d. Consider which other services members access and how could they be tied to behavioral economic incentives to improve patient compliance. Would things such as bus passes, child care, “slots” in services, additional dollars loaded on SNAP cards, etc. be better supports for members?

11. Improve Approach to Value-added Benefits

- a. Medicaid should consider providing a list of initiatives from other relevant state agencies such as OPH, DCFS and Workforce Development that would be supported by additional resources through value added benefit programs. For example, breast pumps to support breast-feeding, cribs to support safe sleep, job search assistance to support employment, etc.
- b. Medicaid should consider if there is a minimum standard of value added benefits that all members should receive. Suggestions include:
 - i. Dental care for adults
 - 1. dental hygiene also impacts social determinants of health, such as the ability to gain employment
 - ii. Breast Pumps
 - 1. Current process of MCO referrals to WIC for breast pumps is inadequate; yields low utilization and presents many barriers to continued access.
 - iii. Continuous Glucose Monitoring Systems (CGMs) for Type 1 Diabetics
 - 1. The Endocrine Society recommends CGMs as the gold standard of care for both children and adults with Type 1 diabetes.
 - iv. Hearing services for all ages such as exams, screening and treatment, hearing aids, and translation and on-site interpreter services upon request.
- c. There should be no reason to limit value added benefits if there is no cost to the state; this needs to be looked at as one of the benefits of managed care over Fee for Service.

12. Achieve Administrative Simplification

- a. MCOs should not be allowed to interpret the Medicaid provider manuals differently. If Prior Authorizations must continue to be used, then they should all utilize the same ones across the board to reduce variance.
- b. Family Planning should not be considered separate from the rest of the Medicaid Provider Manuals by the Plans and up to the plans for interpretation. For example, some of the plans continue to refer to the old Take Charge waiver, which only covered women. Medicaid could streamline the manuals to make it easier for the plans and therefore the providers.
- c. In addition to member satisfaction and health outcomes, provider satisfaction with the MCOs and the Medicaid program is critical to program success. Providers should be regularly surveyed by both MCOs and Medicaid to identify areas for improvement in the relationship. These surveys should be publically available and potentially tied to incentive payments. Additionally, a more robust system needs to be developed by Medicaid for providers to report challenges with MCOs and should include prompt follow up and communication back to the complainant.

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