INTEGRATION ADVISORY GROUP MEETING MINUTES

DATE: JANUARY 30, 2015

TIME: 1:00PM – 4:00PM

Time	Activity
1:00-1:15pm	Introductions: • *Dr. Rochelle Head-Dunham, OBH Assistant Secretary and staff* • *Ruth Kennedy, Medicaid Director and staff* • *Jeff Capobianco, National Behavioral Health Council* • *Lisa Gentry, LA Public Health Institute* • *Calder Lynch, DHH Chief of Staff*
1:15-1:30pm	Statement of Purpose for the advisory group delivered by Dr. Dunham
1:30-3:00pm	Round Robin Discussion – Group Breakout facilitated by Jeff Capobianco and Lisa Gentry
3:15-3:45pm	Group Facilitator Report: 1. How can the provider credentialing process be improved or standardized among the five plans? • Theme across all groups is managing the timeline (i.e., when can credentialing start?); don't wait till 12/1/15. • It is problematic for agencies to credential with all 5 plans, and will likely result in complications with pass-through services transitioning over from LBHP to Bayou Health • Recommendation to see one standard process, possibly using single database such as CAQH, which includes information on providers credentialed with Medicaid that can be used and provided to health plans • Advisory group would prefer that agencies with multiple facilities be credentialed at agency level with roster of providers included • Contracting requires credentialing, which is already an in depth process, so providers do not want to also have to go through certification through OBH. • Group would also like to see that providers already accredited be recognized and credentialing be streamlined • If credentialed already with a Bayou Health plan on its commercial side or for primary care already, recommend not duplicating the process—simply use what can transfer over • Recommendation not to close the network for any specific provider types. 2. In what ways can DHH ensure that health plan utilization management policies, including authorization requests and document requirements, are consistent and rational? • We need consistent processes and published criteria • Share open and honest information/criteria • Health Plans must have knowledgeable staff in behavioral health including both mental health and addiction • Set timelines for communication • Set rules, communicate them clearly, and follow them

- DHH on the micro-level should look at past and current utilization and compare to ensure authorizations are legitimate across all plans; continuously improve monitoring efforts
- Health Plans should submit standardized comparable reports
- DHH should monitor and ensure benchmarks met and institute penalties if not
- Ensure that all Health Plans have a minimum level of behavioral health utilization within each contract and share information with public and providers
- Establish an appeals process to include a neutral arbiter with appropriate definitions
- Denials need to contain specific information to providers
- DHH should have contract language for submitted claims and not just clean claims
- Have consistent documentation requirements and dissemination across all Plans
- Establish financial disincentives for lack of timeliness and non-compliance with policy
- Establish consistent and reliable doctor to doctor communication
- Provide clear documentation for levels of care with clear definitions
- DHH to review policies that regulate the Plans and ensure they are able to be instituted (e.g., requirement for post-discharge signatures)
- Establish timeliness on third party entity signatures
- EMTALA law pushes costs onto providers; honor Physician Emergency Certificates (PECs)
- Discharge planning/authorizations need to include all providers to have an appropriate plan
- Create a policy to establish integrated communications with a timeframe.
- Identify depository for information on how to connect with the Health Plans
- DHH should require the Health Plans to have one shared claims submittal system or DHH should have one repository and forward to the five Plans.
- Have standardized forms and service units including a basic/minimum required number and level of services
- If indigent care is carved out of the new integrated model, requirements for services and cost per unit should at least be comparable to Medicaid clients
- Need more transparent and proactive communication on denials
- DHH contract should require each Plan to establish an algorithm and post it on the Plans' websites to specifically delineate which utilization measures are important to them. Include how Plan will mine that data from providers (e.g., will there be a required EHR?)
- DHH or Health Plans need to communicate how utilization measures will be identified and collected. Measures should be observable and measureable and published prior to 12/1/15 on a website. Include definition of utilization management in all contracts.
- Each Plan needs to publish its definition of medical necessity on its website
- It is recommended that there be a common authorization process with common forms and procedures
- Recommend that prior authorizations not be required in an outpatient setting
- CPST/CI should not require authorization for first 6 months; ongoing authorization after first 6 months should require concurrent review
- Do not exclude bill for mental health services on same day as medical care
- Create standardized tools for primary care assessment and screening
- Increase infrastructure in rural areas

3. What information sharing requirements and standards should exist between health plans and providers?
    - Provide Beneficiary Clinical Summary to improve the coordination of care across provider settings

	• For treatment planning and discharge planning purposes, provide additional insight into the patients clinical history in both primary care and behavioral health care setting
	• Have a common basis of EMR / EHR systems specific to behavioral health (a lot of smaller providers still document on paper)
	• Give providers access to provider relations individuals to help assist in communication
	• Transmit primary care information across care settings to improve treatment of behavioral health patients
	• Combine behavioral health and physical health into the overall treatment
	• Eliminate barriers to providers who are experiencing issues with developing contractual relationships with the Bayou Health Plans' free standing post-acute care setting facilities
	• Bayou Health plans should have case managers to assist providers in discharge planning for BH patients as an on-sight resource
	• Clinical Advisor data should stay intact as it currently exists so that providers will be able to access the entire healthcare record as it currently exists without risking data corruption by transferring it to a different data repository
	    • John Gianforte - Concern for those using EHRs being able to extract clinical records out of CA moving forward after it terminates (import/export function)
	    • Sharing of data between data sets as per HIPAA/42 CFR is a general concern
	• Break down walls and barriers in order to treat the "whole person"
	• State should provide technical assistance to providers that find themselves shopping for a new EHR
	• Improve communication in transitioning a patient from an in-home setting to a community-based setting (a huge communications gap currently exists in CSoC referrals)
	• Create standardizations across the drug formularies for behavioral health (one standardized formulary)
	• Create standardization of eligibility criteria and services across all 5 Bayou Health plans
	• Create standardization of benefits each plan offers
	• Implement a prescription monitoring plan for behavioral health medication that physicians could access
	• Enable viewing of open authorizations for behavioral health services so that primary care physicians have ability to access this data
	• Allow for integration of records between the primary care and behavioral health setting (even in the case of a plan subcontracting out the behavioral health services)
	
	4. What provider education and training opportunities would be most valuable, and how can they be best delivered to ensure their effectiveness?
	• Make sure administrators and providers have clear explanations about expectations and requirements from varying health plans with a robust system for accessing information on CPT codes, eligibility, payment, etc.
	• In order to avoid missteps, clinicians should be allowed to train the health plans on mental health first, before the plans start offering training and TA to providers. After which, follow-up with training from the plans to the providers.
	• General concern expressed about need for more orientation for consumers; consumers should participate on panels and groups of plans making decisions.
	• Training for non-clinician parties and non-providers (i.e., judges, etc.)
	• Request for evidence-based practice (EBP) trainings and disseminate them out to practitioners; contracts with providers should be linked to utilizing EBPs

- Professional training in integrated behavioral health and care coordination
- Trainings statewide on: ACE, evidence-based treatment options, trauma informed care, cross training across divisions, and particular populations being served; partner with education systems as needed
- Include peers on training teams
- Support needed for peer support training and utilization including reimbursement and certification, which should include family and youth support specialists (would like an online survey to be sent to them for participation in this advisory process)
- Provide training across divisions in DHH and its partners relative to what clinicians are doing
- Consistent discussion about need for what integration actually is, what it looks like moving forward, is it required, outcomes, etc. Include face-to-face trainings initially but move to webinars, conference calls, etc. after
- Trainings on communication protocols with the plans
- Insurance requirements often conflict with licensing requirements so it needs study to avoid issues moving forward with new health plans
- DHH should establish an internal group that can give quick response turnaround within 72 hours
- Standardized claims and training; screening and assessment tools in primary care; how to link primary care to behavioral health and connect all to health plan contracts
- Building infrastructure in rural communities and building telepsyschiatry
- Judges are important and need some of the most education because they are often the entry point into this system
- Work toward gaining support/financial interest in training for integrated behavioral health in all the different disciplines
- Have sensitivity training for deaf mental health services
- Training needed in parity issues to avoid relapse in Serious Mental Illnesses

5. How can DHH ensure that health plans have adequate networks of a diverse set of provider types?
    - There has to be an increase in the financial incentives to ensure operational reimbursement
    - There is a concern that not all providers will be interested in contracting with all 5 health plans because of demographics or other reasons. This causes a disconnect to services. The process has to be simplified and incentives offered in order to encourage enrollment in provider networks.
    - Need uniform regulations across all 5 health plans
    - Integration puts the credentialing burden back on providers. We need to incentivize plans by maybe grandfathering in providers that made 18 months for CARF accreditation with Magellan or consider credentialing all current Magellan providers.
    - Have standard reimbursement timelines
    - Concern over provider network in rural areas; have incentives (financial) for relocating, etc. Ensure there is a variety and all providers are included many new providers want to be included; determine by provider types.
    - There is a high administrative/financial expense for smaller organizations when joining 5 plans compared to one, especially for non-profits; would help to have initial start-up incentives or capital incentives.
    - Need DHH to really evaluate and monitor what's considered in definition of network adequacy; monitor waiting lists/capacity of providers. If providers are not taking new clients, then it's not an adequate network.
    - Rate differential for psych services between Medicaid and commercial insurance is too

	great, and we need to close the gap to keep them or bring them in the network. Currently, psych rates are minimal. • Starting 12/1/15, Bayou Health plans would develop a list of preferred providers for higher rates as in a pay for performance system. 6. What special requirements or protections should exist for non-private provider partners, such as local governing entities and other statewide agencies? *NOTE FROM WORKGROUP: This includes Local Governing Entities (LGEs), state departments/agencies, courts, and faith-based community/non-profits. Typically these entities have legal authority as a traditional safety net with 24-hour access.* • Recommend we secure input from the partners on an ongoing basis and provide information to the partners, because often feel they are left out of the loop • Cross-communication is needed, especially for a child in court custody that crosses many agencies • Entities should have access to all qualified providers for each plan; all contracted providers should be contracted in the all the plans • Work toward funding all current services which have been developed during the LBHP (EBPs, Multi-Systemic Therapy, etc.) • Medicaid waivers should include all continuum of care services for children as per federal mandate; maintain the requirement for a continuum of care for adults • Have the entities follow the same credentialing process as for-profit providers undertake with the 5 plans • Fund agencies directly through the General Appropriations Bill (HB 1) with the legislature so that uninsured can be served without having to go to Emergency Room • Create protections such as protecting from any mandate to serve without funding; eliminating barriers to accessing the 5 plans; provider notification of upcoming budget cuts; and continue including and funding addiction services • Caddo Parish Juvenile Court requested that DHH slow the process for integration down, especially for CSoC
3:45-4:00pm	Closing Remarks/Next Steps: • What about uninsured population? DHH to send notice to advisory group when Request for Information released. • Can state funding be reallocated to other providers than those an RFI/RFP may produce? Depends on funding which is predominantly appropriated to LGEs which started as DHH regions. Spreading that funding to a new provider pool is not feasible at this time because right now we need to work through initial transition. There are several requirements attached to Federal dollars, so many things will have to stay the same as far as the sources for uninsured service provision. • Status of contract negotiations: new contract starts 3/1/15 for 9 months. It's at the Division of Administration and awaiting all state approvals, but we have worked through all negotiations in conjunction with Magellan. • DHH will disseminate a survey after the meeting via Survey Monkey for follow-up questions, views on the meeting, anyone additional to be included, etc. • Questions can be sent to IntegratedHealthCare@la.gov • Minutes will be shared on Integration webpage at: http://new.dhh.louisiana.gov/index.cfm/subhome/43