INTEGRATION ADVISORY GROUP MEETING MINUTES

DATE: FEBRUARY 20, 2015

TIME: 1:00PM – 4:00PM

Time	Activity	Facilitator

1:00-1:15pm	Opening Remarks: First Meeting Summary & Logistical Changes
	• Clarity offered on the purpose behind this advisory group:
	  ○ As mentioned in all of our announcements and press releases about integration, DHH is very interested in stakeholder involvement and convened the group as an advisory group to the Department
	  ○ We aim to respond to every concern and incorporate as many recommendations as possible into the integration plan moving forward
	  ○ These sessions were never intended to be DHH presenting its detailed integration plan to the public because we wanted your input first; however, we have been working steadily in preparation for December 1st
	  ○ We have decided to hold a fourth advisory group meeting that will:
	  ▪ Wrap up our work here
	  ▪ Discuss the Department's plans for integration
	  ▪ Have presentations from each Bayou Health Plan
	• Based on survey feedback, we have rearranged the 118 meeting room to allow for more space.
	• We have reserved a second room for the public/audience to observe via webcast and participate in the recommendation and discussion process.
	• Based on your survey comments, we will be making some structural changes to the meeting format today.
	• Regarding your suggested logistical changes, we have made some modifications to the layout:
	  ○ Noise level: This room is the largest available to accommodate the group, so we must work within its parameters. We have repositioned the room in hopes that overlapping conversations will be reduced.
	  ○ Separate room for the public: The public will still be able to observe the start and end of the meeting, but will also be compiling its own list of recommendations.
	  ○ You are welcome to move to the next question when you are ready; however, we will be allowing time for everyone to answer every question today (20 minutes per)
	• Integration is a DHH initiative; Medicaid is the lead with collaboration and guidance from OBH
		Dr. Rochelle Head-Dunham & Lisa Gentry

	• Minutes from the last meeting have been posted on the integration website • We are compiling responses to all recommendations from the first 3 meetings that will be available on the Integration website before the final meeting in April	
1:15-2:45pm	Round Robin Discussion – Group Breakout	Lisa Gentry
2:45-3:00pm	Break	
3:00-3:30pm	Group Facilitator Report: ***What special provisions should exist for health plan requirements for treating individuals with serious mental illness (SMI), co-occurring disorders, or at-risk youth who have been served in the Coordinated System of Care?*** 1. Seamless transition into a new structure to ensure providers stay the same (retain all current credentialed CSoC providers) and that youth currently receiving services see no interruption in their care 2. Licensing process for group homes should be streamlined since there are only 4 in the state now; should be able to hold or obtain a group home bed while the child is in the hospital for discharge into next level of care 3. Structure same CSoC reimbursement requirements across all plans 4. Streamline CSoC provider licensing process 5. Boards/commissions would like to see timely payment for claims with no delays using lines of credit *6.* Need emergency care for children, and how is state addressing issue when a child stays in inappropriate settings too long? 1. Developmentally Disabled (DD) children are not able to access mental health services as needed because of the DD diagnosis so need clarity and rectification; do not restrict them because of diagnosis; increase PRTF network for this population 2. Need navigators for members and providers through payment systems of the plans and to know what services are available to members 3. Providers should be able to have a system to appeal to when turned down for recommendations for treatment 4. Standardized reasonable reimbursements from all Bayou Health plans 5. WAAs should be notified of associated Bayou Health staffing ahead of time and give input 6. Concerns about inpatient stays being too brief causing relapse; need more structure to prevent penalization to providers or members for relapse, especially with addiction 7. What is the plan for community based services to continue? Need more prevention; identify at-risk children with more clear definitions of who these children are and much earlier in the system (e.g., schools, etc. rather than after they've entered OJJ care) 8. Address current lack of adequate discharge planning after inpatient services delivered 9. More local active councils and participation with CSoC 10. Have less expensive and invasive models of care; research other states with certified peer-run models, especially with adults; more housing options and supervised living options 11. Concerns about juvenile judges ordering treatment that is not readily available 12. Raise the cap of number of children that can access the system (CSoC)	Lisa Gentry

	13. Open CSoC services to all home and community based providers 14. What is treatment and funding availability for parents of children in the system? Suggest using same procedure codes. 15. Eliminate periodic assessments which become roadblocks to treatment 16. Create special provisions for serving clients who were deaf and getting them the right level of care 17. For members changing plans and chasing authorization, limit their ability to switch or honor current authorizations 18. Do not require pre-authorization for people being seen through Magellan currently 19. Consider reimbursing addictive disorder day treatment programs for adolescents who are not co-occurring 20. Focus on early/infant behavioral health through CSoC 21. Develop a plan for rectifying current issues and shortages in crisis stabilization and short term respite care under CSoC; authorize crisis stabilization up to 3 days 22. Recommend not capping the number of days or admissions for youth with Serious Mental Illness (SMI) in hospital since there are often multiple hospitalizations required; allow for full reimbursement. Do not penalize chronic admissions. On the other hand, qualify Partial Hospital Programs (PHP) for CSoC youth to prevent/mitigate re-hospitalization/Psychiatric Residential Treatment Facility stays. 23. Ensure that current services and current providers for SMI or CSoC children are not severed by forced integration. The recipient, not the system, determines service end. 24. Ensure better access to mental health rehab for youth; can't use behavioral health in FQHC or outpatient rural health so leave providers for rehab intact since rules are more flexible for rehab only psychiatrist visits. 25. Have one single exchange or administrative organization for CSoC; have a single contact point for CSoC and have 5 Bayou Health plans be identical in procedures and policy relative to CSoC. 26. Create both rural and urban models for care 27. How are five Bayou Health plans going to monitor numbers of youth enrolled in CSoC? 28. Have all 5 Bayou Health plans identify a tool for level of need and base rates on the assessed level of need 29. Create a living room model with peers to run a place to debrief members; research other state models and consider least invasive models such as the Fountain House Model or Arizona (David Covington training peers; internship for people in recovery) 30. Continue peer-run warm line 31. Create Drop-in Centers 32. Who is identifying the "at-risk" youth and what are criteria? 33. Identify or build a continuum for treating youth with SMI or in CSoC with prevention, early intervention and system of care (psych/telepsych, outpatient, care coordination, mental health rehab, integrated behavioral health in primary care, etc.). Adapt the continuum to urban and rural environments. 34. Have a plan for transportation of families to participate in treatment 35. Need more trauma informed interventions 36. Have health plans identify the child receiving behavioral health medications or treatments via primary care provider before they enter the CSoC system 37. Create alternative treatments such as exercise, yoga, mind/body programs, meditation, etc. for children 38. Fund co-located or consultant time of Primary Care Physicians	

	39. Who will be responsible for network development: five Bayou Health plans or OBH? ***What technology requirements should exist for the health plans for care coordination and data transmission?*** 1. Platform should be same across all plans 2. Providers need authorization and eligibility dates in real time 3. How many units of service remain? 4. Which providers are authorized for which services? 5. Rural communities need full continuum of care including telemedicine 6. As services transfer to another provider, there needs to be protocol for transfer of records; statewide health information exchange for clinical data 7. How will small providers obtain electronic health record (EHR) access that's affordable; how will education on options be provided for those providers? 8. Technical assistance is needed to all providers on EHR; what will it look like? 9. What is emergency plan for data safeguards and sharing in the event of a natural disaster? 10. Each plan should have a secured digital method of transmitting authorizations that is not email. 11. Software should be shared by all pharmacists for all medications covered. 12. State EHR should replace Clinical Advisor which should be imported including claims info. 13. EHR is cost-prohibitive for smaller providers so DHH should host it or offer other options going forward. 14. All five Bayou Health plans should provide client profile information to include visits, medications, etc. and all providers should have access to the client history including LSCWs and counselors. 15. Allow for free claims processing 16. Have a clearinghouse for authorizations 17. Authorization disputes should be easily addressed 18. All information should be dated and time-stamped 19. Firewall highly protected info for non-authorized users 20. Create standard electronic face-sheets for basic demographics of members 21. Have a common data format and unified member ID; data should follow the member when switching plans 22. Bayou Health plans should have info on members in advance to do analytics on members being served 23. Provide training and education on HIPAA and 42 CFR requirements surrounding sharing of data and care coordination 24. Early Steps program needs access to EHR ***How can we promote the use of multidisciplinary care teams to use methods such as co-management and co-rounding for patient care needs?*** 1. Need lots of technical assistance to care teams to support shift to integration over time 2. Maintain current wrap around services; should provide positive continuity care with adequate rates 3. Utilize models such as Assertive Community Treatment and Permanent Supportive Housing and other evidence-based practices 4. Include patient's PCP as part of the multidisciplinary team 5. Provide a method where all care team members can view patient's status specifically by using a consistent EHR. Would not recommend using a mandatory	

	HER, but utilize the capabilities of a statewide or community wide Health Information Exchange. 6. Do not recommend continued use of Clinical Advisor, but would recommend historically archiving data through DHH in an electronic platform that will remain accessible. 7. Bundle rates that would benefit a core group of beneficiaries that are high users of disparate services. Example would include group of people that are frequent fliers that use case management, day programs, and receive housing (e.g., demonstration in north Louisiana). This brings in alternative methods of care delivery into the service offerings (Note: not in favor of overall bundling of rates) 8. Be as expansive as possible when looking at holistic models of care. 9. Encourage expansion of co-locating primary and behavioral care; reimbursement models must be at acceptable levels. 10. Facilitate transition of knowledge sharing between primary and behavioral health specialists. Structure incentives that drive toward team planning. 11. Build in crisis services that can provide immediate response in the time of crisis. What is the state's plan to address patients in an immediate crisis state? 12. Providers would benefit from greater access to the complete historical medical record on a patient in crisis 13. Develop crisis intervention teams for example: Mobile Urgent Treatment Teams (MUTT) 14. Explore expanding services covered in waiver programs to include more access to wraparound services 15. Louisiana lacks providers that are trained specifically in treatment of trauma or crisis in pediatric populations even though the majority of behavioral health treatments are being provided by pediatricians. 16. Improve co-management of patients at discharge 17. Have authorizations place more value on the opinions of other licensed providers and not just MDs (currently the MDs notes are the sole focus of pre-authorizations). 18. Utilize patient navigators 19. Promote co-location of services and better coordination of services through improved reimbursements. Address reimbursement shortcomings in providing payment to multiple types of providers for co-rounding. 20. System design should not require that behavioral health treatment must be prior authorized by the primary care physician. 21. Caution against elimination of patient choice when it comes to co-location of behavioral health and primary care. Specialists in each discipline still bring value and valid contributions to the care of the patient. 22. Focus in the state must shift from payment for care and move toward coordination of care at the local level. Should not be driven by payment mechanism, should be driven from care level 23. Expand behavioral telehealth opportunities 24. Plans should establish provider care requirements such that they review primary care issues as part of their behavioral health plans and that primary care providers will review behavioral health issues as part of their primary care treatment plans. 25. Plans should establish quality indicators to monitor this activity 26. CM / UM functions should include identifying those members who have both a primary care diagnosis and a behavioral health diagnosis and determine the need for care coordination and what type of coordination. Providers would be notified of the need for care coordination and be required to supply a plan for such coordination; the Bayou Health plans would establish metrics for measuring care	

	coordination and specific outcome measures to detect if such coordination is producing better outcomes 27. Establish a bonus reimbursement system based on providers supplying data showing integrated care coordination similar to the CMS PQRS system 28. It may not be feasible to set up a system of "rounds" among participating providers due to the large number of members involved and time demands on providers. Coordinating schedules would be difficult. An alternative to such synchronous "rounds" would be asynchronous "rounds" such as using IM functions within a secure portal or within an EHR whereby participating providers can share critical information pertinent to each provider that indicates that they have reviewed the information. This data could be used by the Bayou Health plans as part of the plans' QA function. 29. The issue needs to be addressed of responsibility. Who will be responsible for the creation of multidisciplinary care teams: Bayou Health Plans, OBH or the LGEs? Should involve coordination of the three but with ultimate responsibility with Bayou Health. 30. Truly integrated care should include points of contact outside of the physician network, i.e., teachers and school nurses play a pivotal role in the care of children ***What protections are necessary to ensure continuity of care during the transition?*** 1. Need information on services offered and by what unit of services 2. Same day payment structure at issue with primary and behavioral health care; how will this be addressed? 3. Previous experience has left many providers still suffering from claims issues they experienced during the transition to Magellan. How will these be addressed? 4. Special consideration needs to be given to non-Medicaid services 5. No delay in payment 6. Authorization process by Magellan in November needs to carry over into December of 2015 and accepted by the Bayou Health plans 7. Needs to be deadline before December 2015 where the provider looks at their caseload to determine each member's Bayou Health plan in case the provider is not contracted with that plan and appropriate transition planning and care coordination procedures need to be put into place to ensure continuity of services for the member. 8. Need a user friendly claims process with a single point of entry for behavioral health services 9. Need pre-established single case agreements for members needing services in their areas for providers that are not in the Bayou Health network for residential services 10. How can the state ensure continuity of care without one SMO for residential and inpatient services? 11. Providers must have access to the information stored in Clinical Advisor free of charge for 7 years and longer for children's records 12. Providers' web access to verify benefits and eligibility similar to MagellanofLouisiana.com; need health information exchange 13. Need an independent watchdog group/neutral party to monitor integration/transition process and report to legislature 14. No members should lose any services and no members should be dropped from plans during transition 15. All providers currently in the LBHP should be given a period of time to be grandfathered into the Bayou Health network (suggest 12 months). Those that are already accredited should be accepted by all plans.	

	16. Special consideration for rural community providers is needed to exempt them from accreditation requirements under the premise that DHH will do annual monitoring. This would assist the smaller rural providers that can't meet the financial demands of accreditation. 17. Staff capacity with the Bayou Health plans needs to be increased to accommodate increase of authorizations, claims issues, and provider services 18. Home and community based services need to transition to Bayou Health with no changes from the LBHP model, including current infrastructure. Regardless of which Bayou Health plan they are in, all members currently receiving services should automatically be authorized to protect them from interruption of services. 19. Consumer needs pointed education on who will be handling their mental health needs. Huge area of concern as Magellan call center is terminated. Consumer and family members need to be included in this transition. 20. Needs to be real consideration to current rates for services and to make them more comparable to private rate structure in order to sustain model 21. Bayou Health plans need to measure outcomes and utilization to create preferred provider rates with incentivized higher rates and a preferred provider list published online 22. Compare Bayou Health plans against each other for performance based measures 23. Allow for provisional credentialing with limited documentation (i.e., license, malpractice insurance, and resume) since the large hospitals contract with individual providers 24. How much notice do Bayou Health plans intend to give to members if being dropped from the plan? Sufficient education needed on next steps at member level. 25. Will plans do training as Magellan did before it launched LBHP?	
3:30-4:00pm	Questions/Answers & Closing Remarks: • **Will CSoC continue?** Yes • **What is being done to address Southern Poverty Law Center issues in letter to CMS?** There are some areas where we haven't met the mark of pulling in providers. Now we are trying to sort through the barriers and instituting corrective measures to meet urgent needs. We are not ignoring any of it, but trying to work through the details. • **Has DHH started discussions for a single formulary within Plans?** No single formulary is anticipated, but we are still drafting the contract amendment. Though there is interest, it's premature to respond definitively at this time because we imagine there will be variation among the Bayou Health MCOs, though we are trying to streamline authorizations. Classes of medications had to be the same as per the RFP, but not specifically the same formulary. • **Status of records in Clinical Advisor and planning for EHR?** No change to current records as they are in Clinical Advisor now. A large communication plan is being developed so providers can retrieve the data long before transition occurs. Bayou Health does not offer a free EHR like Magellan, but OBH will provide information on obtaining your own EHR, including questions to ask when choosing one. DHH is putting together an EHR vendor fair, though no specific vendor is recommended by DHH. We are getting contacted by many vendors, so the fair will allow them to set up and present to providers.	Lisa Gentry & Dr. Rochelle Head-Dunham