April 17, 2018
Volunteers of America (Greater Baton Rouge and Southeast Louisiana)
Select Managed Care Polices and Related Questions for Stakeholder Input

Recommendations:

a. Limit the number of state MCOs; less than five but at least three. When there is only one MCO they tend to be very limiting and take a one size fits all approach without any innovation.

b. Have simpler authorization standards and longer authorization periods. Give more flexibility and increase the number of units within the authorization period. Have a standardized authorization form and process that all the MCOs use. In addition, adopt a uniform Treatment Plan. Credentialing and roster requirements need to be similar in scope for all MCOs; a standardized process. MCOs to host quarterly provider/member focus group meetings to learn what's working and where revisions or enhancements need to take place to ensure member/provider satisfaction.

c. Enable Telemedicine to be accessed in rural and under serve areas. Consider reimbursement for travel time and collateral contacts. CPST and PSR are needed services; case management/care coordination is a valued service which isn't provided. Client needs assistance in identifying community resources and assisting them in referrals for housing/employment opportunities, securing housing, transportation, and access to food and monetary assistance.

d. See response to c

e. Provide financial incentives to programs for coordinating physical health and behavioral health needs, while focusing on integrated care with holistic outcomes. For example, if a person is seeing their doctor and complains of depressed feelings, a therapist located at or near the doctor's office, can provide a therapy session without prior authorization. The challenge, a clinician/provider has no means of knowing if the client has utilized their 12 visits or not until they bill and are denied or paid.

f. This is done in California. VBP requires numerous audits. Also, providers are paid upfront and if the money is not spent then it is returned at the end of the contract, which incentivizes providers to ensure they spend down the full amount and opens providers to fraud

investigations. Also, since auditing is down for prior contract periods, evidence of proper fund usage can be difficult to provide. A more simplified fee for services system may be easier to implement, such as the one used in MD. MD's fee for services system breaks services into two types, therapy and psychiatric rehabilitation. Though these are similar to CPST and PSR, the way units are distributed is simpler. Authorization is requested separately for each service type and granted for 3 month periods. The provider manages the units based on services needed in the authorization period. Instead of therapy being provided in 15 minute increments, the provider may use 1 unit to represent a 30 minute session, 45 minute session or 90 minute session, each with a correlating reimbursement. A PRP unit represents 1 hour of services with a correlating reimbursement. To add to this, a concept of a flat rate for a month of service would be helpful and move away from the traditional unit structure. The MCO's need to work with the providers, not hinder our delivery of services. It is recommended MCO's clearly articulate needed services and to all providers and not a select few providers and offer everyone an opportunity to bid or provide proposals to provide the services.

g. MCOs should not require community health workers. MCO's providing score cards to evaluate performance on a routine basis would be helpful.

h. Consideration should be given for non-traditional forms of reimbursement. We are limited as we only get reimbursed for face to face service. To adequately influence change in the social determinants of health, it takes much more than just face to face visits. MCO's appear to have difficulty providing a clear delineation of the difference between CPST vs PSR services to providers. Providers would benefit from training on the difference and how they determine when each service should be used.

I. No recommendation

J. Many of our clients do not utilize the incentives for healthy behaviors. It would be effective, if the incentive was given more immediate (when the service is performed)

k. Any benefit provided will be at a cost to providers or the MCO. Value added benefits do not work for enrollees in the behavioral health sector. However, I do believe value added benefits for the providers (meeting certain targets and etc.) would be helpful and effective.

l. For providers: limit the number of MCO's, have the option of electronic format and submission of authorizations, move toward one authorization process that the MCO's follow. Longer authorization periods for special populations-chronic mental illness and children.