

Meeting Agenda – SR260 Work Group

MEETING INFORMATION

Date:	09/16/2019	Location:	Zoom
Time:	8:30-10:00	Meeting Type:	Ad Hoc
Call-In Number:	Zoom	Call-In Code:	Zoom
Facilitator:	Jackson Carney	Note Taker:	Jackson Carney

TOPIC: SERVICE DELIVERY SYSTEMS LANDSCAPE

AGENDA ITEMS	RESPONSIBLE	DUE DATE
1 Definitions	Jackson Carney	
2 Structures	Jackson Carney	
3 Landscapes	Jackson Carney	
4 Jeff Capobianco, National Council of Behavioral Health	Jeff Capobianco	
5 Further areas of research	Group	

Work group members:

Agency/Organization	Name of rep for workgroup
LDH Secretary (or designee)	Christy Johnson
OBH Assistant Secretary	Karen Stubbs
Medicaid Director (or designee)	Mark Liker
Governor's Office (one member, designated by governor)	Nick Albares
Executive Director of LA Medicaid MCO Association	Kathy Kliebert
President of the LA Behavioral Health Providers (LABHP)	John Gianforte
Up to 12 members of LABHP (selected by President)*	Mike McNeil Rob Salus

	Collette Melancon Chris Mudd Donnie Oliver Foley Nash Ben Thomas Matthew Delk Adrian Turner Tibberly Richards Lisa Romback Earnest Airhia
President of the LA Medical Society	Ann Conn
President of the LA Hospital Association	Greg Waddle

Jeff Capobianco of the National Council of Behavioral Health attended the meeting to discuss the national landscape of carve-in/carve-out.

Notes

#1 Presentation

#2 **JEFF CAPOBIANCO:** Looking back traditional at how Medicaid dollars are managed, the state itself has managed and worked directly with the providers. As costs and complexity of delivery of care going up (laws at federal level like parity), we've seen a movement towards MCO to manage the \$

Expansion of Medicaid managed care plans led to an uptick in Medicaid MCO model. Typical as Medicare goes, Medicaid goes later.

Still relatively early in the life cycle, data is limited on how well MCO systems work, as well as carve-in and carve-out. MCOs struggle to work with Medicaid population. If you look at the data related to people who receive services, jury still out as to whether or not MCO vs traditional ffs works better for members. Consternation from providers around changes. Will take time to figure out if MCO system is better, same with carve-in/carve-out or any variation thereof. Going back to a carve-out would not necessarily fix the issues present in Louisiana.

KAREN STUBBS: Lets focus on pros and cons. Last time was specific clinical barriers. Lets open up for conversation around pros and cons of different systems.

KATHY KLIEBERT: Does the data show any states doing carve-in well? Jeff: white paper coming out with shine more light, but one thing they have seen is when you create a change in a system there's a disruption, which takes time to settle. Not sure if we know what states are doing well yet given how relatively new these different delivery systems are. Kathy K: Ask about states that have done it the longest? Jeff: FFS states have done carve in the longest, no MCOs involved. Members tend not to notice difference.

ROB SALUS: Question about integration at the payor level & how that tends to look.

CAPOBIANCO: State entity executes contract to use those dollars & how it works with providers as to how some MCOs silo physical health and behavioral health care, different case managers looking at the patients. MCOs often have separate bh arms.

STUBBS: from providers perspective, difference between a United/Optum situation vs MCO that doesn't have that situation. Rob, to some extent yes but largely dependent on company visions.

COLLETTE MELANCON: Bc of the population she deals with being early childhood, almost all cases go to peer review with United. When get to peer review, they typically end up talking to someone who understands what they mean. Tougher when there's no bh specialist to get the claim approved.

GIANFORTE: In his experience, they had better conversations with Magellan as they understood BH when talking to case managers as opposed to MCOs today where case managers may know physical health very well but don't always know behavioral health generally and how it works within Louisiana. Lack of coordination and standardization for various protocols within the current MCOs. Asks Jeff is other states how the carve ins have dealt with lack of standardization.

CAPOBIANCO: anecdotally, other states experiencing the same issues. Jeff suggest require standardization. Issue usually is that businesses don't want to give up proprietary. ***Karen ask if Greg Waddle could speak to hospital experience for the same standardization on the physical health side.***

KLIEBERT: DRGs help with this. Diagnosis related group, takes away some of the back and forth around what is or is not allowed.

CAPOBIANCO: DRG started in 80's, made things simpler and contained costs. Over time the system was gamed & the cost went back up. Case management was never in a DRG set up, two systems kind of at odds over the way to best bill and track outcome measures.

SALUS: Referencing reluctance for MCOs to standardize care. Karen references primary care citing same issues, and administrative simplification group to discuss solutions to this issue whether its CMS related or contract related.

GIANFORTE: suggest lengthening these meetings to 4 hours. *Karen, not sure this report is to solve all issues but rather to identify problems for the report. Invite legal to attend & additional Medicaid staff to attend on both admin and clinical side.*

DONNIE OLIVER: Agree that it almost sounds like we're asking for special treatment in asking for a carve-out, but behavioral health is a lot different than the rest of primary care. When someone gets a shot, it's A or B. If they get an x-ray, do they or do they not have a broken bone. But when a BH provider provides a service, you go and talk to someone. BH is a specialized thing which is why plans struggle with this or start their own in house silos to deal with carve out. He's seen state FFS prior to Magellan and even before that when it was a monthly rate. When Magellan first started, a lot of providers complained about them and did so until they switched to the health plans, but he would bet those providers would take them back any day to deal with only one plan as opposed to 5 or 6. Constantly chasing a moving target. Dramatic increase in frequency of audits, etc. We could talk for 8 hours and still not fix it, what's the easiest way to fix the situation? Been in a carve in for 4 years now and probably the worst situation they've ever been in. Feels most of these problems wouldn't exist under a single plan.

KLIEBERT: While she agrees the issues have increased, the increase in legislative audits in the last 3 years has contributed in a big way to these problems and the pressure it's created for the department.

MELANCON: Us v them mentality between MCOs and providers. Environment of always having to prove themselves, has turned into a punitive process. Audits have been extremely burdensome, losing sight of the product they're providing to the clients. Need to all work toward the same goal. Kathy K, agree there is a punitive environment. John gives example of provider association, when measured according to outcome measures they do well, when measured by process measures they don't do well. Expectation level is too high, illustrates that to get out of us v them we need to identify criteria for the audits that are reasonable and fair. Moving away from process measures to outcome measures. Rob agrees with John.

STUBBS: How can we discuss audits in a productive way? Previous conversation clarified a little bit but has come back up in the last few weeks. What can we do besides talking about audits just talking about what they are and not really doing anything.

SALUS: Previous conversation, types of audits being done was clarified. How the system of audits is being administrated will eventually put every provider out of business. Usually score highly on audits but have had years of payments for a member recouped over a single technicality.

STUBBS: Agencies also closing bc they've abused the system and illegally collected millions of dollars. How do you distinguish between good providers being punished on a technicality. When should an agency be put out of business vs who should receive education and treatment.

MELANCON: should allow space for human error. Shouldn't be an all or nothing mentality re: recoupmnt. Very difficult from a time management. Perfection kills the program. Not only do the MCOs and LDH need to allow some level of error but so does the LLA. 40-60 days of negative cash flow puts these agencies oob. Profit margins only 2-3%

MIKE McNEIL: Talks about standardization. Currently has 5 page, 312 field spreadsheet to deal with auth process over the various MCOs. Experience 30 different kinds of audits under different standards to keep up with.

MATHEW DELK: Agree with Donnie and John. Dealing with audits that may lead to them closing their doors, over 500 clients in Lafayette area. Crossing T's and dotting i's leading to recoupment. Pray for providers to weather the storm.

STUBBS: Discuss amongst ourselves about what kind of audit meeting would help to ease burden. **Replace integrated care to devote to audit.** Be thoughtful about how to structure that meeting & realistic in what the expectation for that meeting. **Next meeting as well, what additional people can we pull in. Break down agenda into specific barriers.** Rob and John agree. **Add room at LDH for meetings and extend next meeting.**

KLIEBERT can get MCO representatives if wanted.