Louisiana Medicaid Managed Care RFP Input
On Behalf Of: Louisiana Psychiatric Medicine Association
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Greetings

In response to the recent bulletin stating that LDH is seeking online input on key elements of the Medicaid managed care contracts, prior to releasing the RFP in 2021, please see the following feedback on behalf of Louisiana Psychiatric Medicine Association (LPMA). As a district Branch of the American Psychiatric Association, the LPMA strives to promote mental health, support quality treatment of psychiatric disorders, and support the professional agenda and standards of our national organization

Behavioral health integration - Louisiana Medicaid seeks to integrate financing models by contracting with MCOs that manage all physical and behavioral health services for Medicaid enrollees to decrease fragmentation of care, improve health outcomes, and reduce costs. Goals of integration include enhancing provider access to data, incentives, and tools to deliver integrated services and coordinate care across settings.

Please offer suggestions on how the MCOs can support key aspects of behavioral health and physical health integration and how they can improve integration of behavioral health and physical health care delivery for enrollees in this upcoming procurement. What specific network development, care delivery, and care coordination services approaches should LDH consider to allow the MCOs to better meet enrollees' behavioral health needs?

<u>Feedback:</u> *Mental health is essential to improving overall health outcomes across the lifespan. Psychiatrists are uniquely positioned to improve access to mental health care and improve the whole health of patients by using effective integrated care models.*

Better care coordination via integration of mental health and primary care has been shown to improve patient access and outcomes. Three decades of research and over 80 randomized controlled trials (RCT) have identified one model in particular – the Collaborative Care Model (CoCM) – as being effective and efficient in delivering integrated care. It is estimated that $26 - $48 billion could be saved annually through effective integration of mental health and other medical care.

However, successfully expanding use of the model will depend on the availability of reimbursement for services related to care management and psychiatric consultation, and infrastructure support for staffing changes and implementation of data tracking tools.

LPMA further urges the expansion and utilization of peer support specialists along with additional clinical staff for home/community visitation of patients in any integration model.

Delivery system reform – In the last couple of years Louisiana has instituted a number of reforms related to payment models and provider network structures that will improve quality of care for Medicaid managed care enrollees. These reforms include instituting incentives such as Value Based Payments, and other incentives for quality care.

Please offer suggestions on the best way to promote adoption of new payment methodologies that reward providers for the value they create as opposed to the fee-for-service methodology that rewards solely on the basis of volume of services.

Feedback: *VBP programs require fundamental changes in the way providers are paid and measure progress, and many behavioral health providers require assistance in developing the capacity to meet new requirements and practices. Behavioral health providers often lack the billing and data collection and reporting capacity to implement VBP models. They must also have the appropriate and often expensive technology platform or other infrastructure to access and share data. Providers may not have the capital to make early investments to assume risk, cover start-up expenses, or manage finances in new payment models when they are not paid per service or by case.*

States and MCOs should consider adopting data collection, reporting, and risk arrangements slowly to ensure time to build providers' organizational and financial capacity. For example, providers may not assume risk initially to allow more time to build infrastructure and gain experience with new clinical and business practices. The amount of provider support required before a VBP program launches depends on providers' level of comfort, technological preparedness, and other resources, as well as the extent to which the new VBP model changes practice models and overhauls payment arrangements.

Some suggestions for increased adoption include launching new programs via a smaller pilot or a phased-in approach, such as:

Year 1: Pay providers for participation in a VBP initiative and reporting on structural measures, while maintaining a traditional FFS or case rate arrangement.

Year 2: Pay providers for meeting process measures, while maintaining a traditional FFS or case rate arrangement.

Year 3: Pay providers for meeting process and/or outcome measures, with providers assuming some amount of risk for these performance measures. In addition to phased-in contracting, states and MCOs can support providers in developing successful programs in other ways. Offering technical assistance to MCOs and providers — or requiring MCOs to offer supports to providers — can be a worthy investment. Interviewees recommended assessing providers' technical assistance needs and offering tailored support, either internally or with a contracted vendor. Recommended topics include: billing, reporting, data collection processes, and care delivery model design. For common issues, structured learning collaboratives with participating providers, ideally convened in-person, may provide a valuable opportunity to discuss common challenges, collaboratively identify solutions, and network with other providers to address similar issues. States and/or MCOs could give providers intermittent feedback on their progress to confirm whether they are moving in the right direction or could benefit from support.

Any VBP addressing behavioral health by MCOs should set a rate for each attributed member for each month specific services are delivered. These services are not traditionally covered under FFS, such as creation of care plans, care coordination, and patient and family support. This should be accompanied by outcome payments. Providers would be evaluated on 15 measures that assess efficiency (five measures, such as all-cause hospital readmissions, emergency department visits, mental health inpatient utilization, etc.) and quality (10 measures, such as psychiatric hospital readmission rates and antidepressant medication management; initiation and engagement of alcohol and drug dependence treatment; body mass index and comprehensive diabetes care; etc.). Outcome payments to providers depend on the extent to which providers

meet or exceed state- and MCO-established thresholds for each measure. In order to be eligible for outcome payments, providers must surpass expectations for at least four of 10 quality measures, and demonstrate improved efficiency (i.e., better results on efficiency metrics during the performance year).
Because most state, MCO, and provider experience with VBP models is in physical health, it is important for states and, as applicable, MCO leadership to identify program management staff with behavioral health expertise. This can ensure that efforts address behavioral health providers' unique challenges during a transition to a new payment arrangement, and can better support troubleshooting with providers during implementation. Based on their behavioral health expertise, these individuals can help generate buy-in and trust with providers. Lastly, given the volume of reform initiatives underway in most states, it is important to consider other related federal, state, and local initiatives and to try to minimize provider burden and ensure multi-payer alignment.

DOJ settlement agreement requirements – In 2018, a Federal Department of Justice (DOJ) investigation found that the State of Louisiana (along with several other states) violated the Americans with Disabilities Act (ADA) by housing mentally ill individuals in nursing homes. Subsequently, LDH agreed to review and add services for Medicaid-eligible adults with a serious mental illness (SMI) in community-based settings under terms of an agreement to resolve the investigation. Care and service integration provided by MCOs will play a crucial part in meeting the terms of that agreement and further advancement of outcomes for this population.

Please offer suggestions for how care and services specific to the SMI-diagnosed population covered by the agreement could be developed to both avoid nursing facility placement and ensure community integration upon discharge from placement.

Feedback: *Deliver support services in a more coordinated fashion. Medicaid services are not always delivered in a way that fits the supportive housing model. Services are often delivered only within the confines of an office, without coordination among providers. Moreover, providers may not focus on preventing emergency room visits or other unnecessary treatment. States could institute reforms in their health care systems to give hospitals, community health centers, and other providers incentives to provide the mobile, team-based services required for supportive housing, and focus on providing more appropriate care. To achieve reforms, states can apply for waivers to some Medicaid rules and amend their Medicaid state plans*

To date, federal and state policy efforts have predominantly focused on supporting integration of primary care and specialty mental health services for people with SMI. The collaborative care model of integrated care can improve both physical and mental health care quality and outcomes. Collaborative care is a primary care-based model in which primary care physicians collaborate with a mental health care manager and a psychiatric consultant to proactively identify, treat, and monitor mental illness. The evidence supporting collaborative care is strongest for depression, although findings from limited clinical trials suggest this model may also benefit people with schizophrenia and bipolar disorder. Specialty mental health-based integrated care models that operate in a manner conceptually similar to collaborative care but with the specialty mental health program as the locus of care, have the potential to improve quality of medical care and physical health outcomes for people with SMI.

There are many challenges to implementing integrated care for patients with SMI. One-sided financial incentives, lack of accountability, and carved-out financing of general medical and specialty mental health services are barriers to implementation. The behavioral health integra-

tion billing codes and most Medicaid health home waivers reimburse only one side of the general medical/specialty mental health duo. For example, the entire reimbursement for the collaborative care billing codes goes to the billing general medical provider, despite the central roles of the behavioral health care manager and psychiatric consultant on the care team. Alternative financing arrangements, such as bundled payments or hub-and-spoke models, may alleviate this issue. Lack of accountability for physical health outcomes in SMI among either medical or mental health providers may impede care integration. Accountability could be improved through models tying payment to performance metrics, particularly models such as accountable care organizations, which can be structured so that both general medical and specialty mental health providers are subject to the same incentives.

LPMA physicians over encounter patients with moderate to severe impairment 2/2 long term mental illness and find it very difficult to find place for such patients who can no longer live independently or have adequate family support. It is common knowledge at the state level and nationally that there is a significant shortage of long term placement for such patients. While LPMA fully supports appropriate and quality placement for these individuals, our membership urges that nursing home placement not be wiped out as an option until appropriate and quality solutions are determined.

Health equity – Health Equity is defined as a state where every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Addressing health equity in the context of Medicaid Managed Care means focusing on improving population health by working to reduce identified disparities for Medicaid populations. Quality improvement and health equity approaches will inform and guide managed care in Louisiana. This will include identifying the key social determinants of health (SDOH) and related outcome measures such as baseline health outcome measures and targets for health improvement; measures of population health status and identification of sub-populations within the population; identification of key SDOH outcomes; and strategies for targeted interventions to reduce disparities and inequities. SDOH are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors.

Please offer suggestions for how LDH can require the MCOs to focus on addressing social determinants of health and other health disparities in Louisiana. How can LDH best hold the MCOs accountable for significantly improving health equity among Medicaid managed care enrollees?

Feedback: *Psychiatrists often function as leaders of interprofessional mental health care teams because of the extent of their education and training, professional licensing statutes, and the by-laws of professional staff organizations at health care delivery sites. When promoted in this role in collaboration with MCOs, psychiatrists have an important opportunity to advocate for improving the delivery of care. Such advocacy can be extended to helping the care delivery organization address identified SDOH. In Arizona, for example, the psychiatrist-in-chief at a community hospital was able to work with the hospital's chief operating officer on a joint venture with a community mental health agency to invest in a temporary residential housing facility for pregnant women with substance use disorder. Under the arrangement, the women receive onsite addiction treatment and prenatal care, then deliver at the hospital and move back into the residential setting for continued addiction treatment. Neonatal and postpartum care is provided*

at the hospital's birthing center. While utilization statistics met or exceeded expectations, the project is too new for generation of outcome data.

The care of individuals with mental illness is incomplete if it is isolated from their general medical care. This insight has spurred the implementation of new care delivery models that, most frequently, add a "behavioral health provider" to a primary care medical home or embed primary care clinicians in a psychiatric clinic. In the collaborative care model, care coordinators are placed as psychiatry extenders in a key position, while integrated care models rely on shared care between psychiatrists and primary care physicians. MCOs could address and further alleviate the SDOH by promoting these models. There is an enormous body of literature on the advantages of such models. The growth in prevalence of chronic health conditions and the increasing share of the nation's health care spending devoted to their treatment make primary care physicians powerful allies in psychiatrists' advocacy of public investment to improve conditions.

A powerful approach to addressing public health problems involves collaboration among multiple systems and levels of care across a wide geographic area. A successful example of this approach is Community Partners in Care (CPC), which involved 95 programs in five sectors to address depression care in Los Angeles. CPC involved enlisting, training, partnering, and implementing mental health care in health care and non-health care organizations. This is an evidence-based way to treat patients with mental illness and address social determinants of health and create community efficacy around health equity.

The Centers for Medicare and Medicaid Services (CMS) is the largest funder of health care services in the country. Over the past 10 years, CMS has generously funded various new models of care delivery and has supported rigorous outcome research. These efforts have resulted in the experimentation with Accountable Care Organizations (ACO) and the creation of new billing codes that allow for the reimbursement of collaborative care. For these reasons, it is likely that CMS will have a major role in addressing SDOH. There are several important issues with the current system of government funding in the health care system. First, targeted awards, such as grants, are tied to the health care system, which limits the flexibility of investing such funds in social determinants of health that may involve other systems like education or criminal justice. This inhibits psychosocial integration. Second, government funds are limited, so the officers in charge of distribution are often reluctant to invest in novel health care approaches. Finally, government may not have the infrastructure to invest in programs addressing SDOH and the tools for implementation and metrics to measure success may be lacking.

Here are some of the relevant federal and state initiatives, the evidence (where it exists) of their effectiveness, and the problems and challenges associated with these approaches: 1. Alternative Payment Models (APMs) under Medicare and Medicaid Waivers APMs under Medicare and Medicaid waivers represent government-funded mechanisms by which SDOH may be addressed. Alternative Payment Models are one track of the Quality Payment Program (QPP) created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). (The other track is the Merit-based Incentive Payment System, orMIPS.) One goal of the MACRA track is to encourage the development of Physician-Focused Payment Models (PFPM) focused on improving health care cost and quality. APMs typically allow for the development of novel payment mechanisms that offer financial incentives for keeping patients healthy and reducing patient need for costly interventions including hospital and emergency department stays. A priority of physician advocacy organizations regarding APMs is to ensure that physicians are not tak-

ing on financial risk for factors that they do not have the resources or ability to control. A benefit of APMs is that they offer an opportunity for flexibility in Medicare reimbursement for support services to address SDOH, which are not typically covered or otherwise funded.

Unfortunately, there is a risk of adverse selection: APMs can disincentivize physicians from caring for vulnerable populations and can limit access to care. Current risk-adjustment methods are not accurate enough to distinguish between high-quality care provided to patients who are at higher risk for illness versus inadequate or insufficient care. Moving forward, it will be important for health care providers to encourage APMs that reimburse for the assessment of—and intervention for—modifiable SDOH.

While Medicaid waiver programs may offer opportunities to fund unique delivery models and address SDOH, these programs may have the unintended consequence of limiting access to care. There is also the concern that these programs may, in some cases, be specifically designed to limit access to care, make care conditional on standards outside of the objective of Medicaid, and/or shift the financial risk of insurance to either patients or providers.

To this end, the American Psychiatric Association, along with other physician and patient advocacy groups, has offered guidance. Waiver programs should accomplish the following:

- *Ensure that affordability protections are maintained and that proposed changes do not significantly increase premiums, deductibles, copayments, and other out-of-pocket costs or establish new requirements for eligibility.*

- *Maintain or strengthen benefits so that the full range of currently covered services is maintained, including essential benefits, maternity care, substance use disorder treatment, and immunizations and services for children under the Early Periodic Screening, Diagnosis, and Treatment Program.*

- *Be free of barriers to eligibility and coverage such as job requirements and mandatory drug testing.*
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- *Maintain or strengthen access to providers of all women's health services.*

- *Preserve existing funding mechanisms and promote a variety of models including patient-centered medical homes, patient-centered medical homes for women, and integration of psychiatric and primary care.*

- *Be transparent and involve multiple stakeholders to evaluate the impact on enrollees, families, and providers.*

Finally, LPMA urges accountability measures and penalties related to transition of SMI individuals from Medicaid to Medicare as they enter adulthood. Individuals in this transition often enter a group home setting where most services are to be covered by Medicare and anything not covered by Medicaid Long-Term Care. These transitions often create a gap in funding and treatment for this already fragile population.