Thank you for allowing providers to submit feedback on the new Medicaid managed care RFP. As the chosen managed care organizations (MCOs) have a large impact on providers daily operations, we appreciate the opportunity to discuss process improvements and improve care coordination.

Provider Background

Odyssey House Louisiana (OHL) is a non-profit behavioral health care provider with an emphasis on addiction treatment. As one of the largest substance use disorder (SUD) providers in Louisiana, the mission of Odyssey House Louisiana is to provide holistic and client-centered services in a safe environment that address the full continuum of special care needs for the state of Louisiana. OHL's encompassing system of care also expands past SUD treatment into primary health care, as OHL operates a Federally Qualified Health Center (FQHC), focused on integrated physical, behavioral, and dietary healthcare, including wraparound substance abuse treatment and HIV/AIDS services. OHL's full continuum of care includes prevention, detox, treatment, behavioral and medical healthcare, life-skills, counseling, and case management. OHL's holistic approach addresses the physical, mental, emotional and social conditions of each client in treating the illness of addiction.

Currently, OHL provides services at ASAM Levels 3.7 (Acute Detox), 3.5 (Inpatient Residential) and 2.1 (Intensive Outpatient).

Based on our past experience with the MCO system, OHL respectfully submits feedback on the areas of interest outlined by the Louisiana Department of Health:

Behavioral health integration - 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?

- ***Suggestion:*** *MCOs should take a more active role in care coordination and be held accountable to how they allow enrollees to move between levels of care. MCOs should be evaluated by the State on how they assist enrollees moving from one level of care to the next*. MCOs have list of referrals statewide (this information is not always available to providers); if an enrollee is being released from Inpatient Residential, the MCO should identify and coordinate which Intensive Outpatient (IOP) programs are available in the enrollee's region. MCOs should assist provider admissions/referral departments with this coordination of care between services to create a more streamlined process.
- ***Suggestion:*** *ER Coordination: If an MCO enrollee is flagged at an ER with an overdose, mental health or substance use disorder issue (SUD), MCOs should assist in coordinating follow up care to area providers.* An ER visit can be utilized as an invention service. MCOs should develop a

billing mechanism for providers to perform intervention services as an enrollee is being released from the ER and help move that enrollee into the appropriate level of care on site.

Child and maternal health outcome improvement –Please offer suggestions on the key aspects of child and maternal health outcome improvement and what strategies could be used to address these aspects. (Some possible topics may include coordination and transition of care, how to increase patient engagement, how to care for special populations for both mothers and children, and suggestions for mitigating trauma and adverse social determinants of health.)

- ***Suggestion:*** *MCOs should utilize all available dollars for child and maternal health services.* Ex: Shortly into the new MCO contracts start date, funding will become available through the federal Family First Prevention Services Act (FFPSA) for states to receive federal Medicaid funding for the provision of SUD treatment for pregnant and postpartum women, parents and guardians and, to the extent applicable, their children, in family-focused residential treatment programs. Together the State and MCOs should employ and coordinate funding provided under the Medicaid program and the title IV–E foster care program to support placing children with their parents in family- focused residential treatment programs and programs targeting pregnant and postpartum women, to support the provision of treatment and services provided by a family-focused residential treatment facility.
- ***Suggestion:*** *Increased Length of Stay (LOS) for Adolescent SUD treatment (90-day minimum).* Due to woefully insufficient authorizations for adolescent services and consistent underfunding, resources for adolescent treatment services across Louisiana are almost nonexistent. Ex: OHL operated an adolescent program for a number of years, but was forced to closed when authorizations would not extend past 15 days at a time. MCOs seem to treat these services as psychiatric stabilization rather than substance use disorder treatment, which requires a longer length of stay for proper behavior modification.

Delivery system reform –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.

- ***Suggestion:*** *Recognize that multiple stays are part of SUD treatment model.* Many MCOs do not want to fund multiple treatment stays, when all common treatment knowledge acknowledges that relapse is part of recovery and that clients often need more than one treatment episode to engage in sustained, long-term recovery.

Disaster planning and recovery –Please offer suggestions as to what barriers to care enrollees and providers encounter during disaster events, and what specific measures can MCOs take in the care planning process to mitigate these barriers.

- ***Suggestion:*** *MCOs should be practice in care coordination pre- or post-disaster*. MCOs should utilize its referral network to identify alternative treatment programs in the event of one city's evacuation plans (i.e. if New Orleans is under a mandatory evacuation or uninhabitable after a disaster, MCOs can work with providers to identify open beds in cities outside of the evacuation zone and even facilitate transportation).
- ***Suggestion:*** *MCOs should be allow temporary leeway/leniency during a disaster event.* Length of stay should be automatically extended during a shelter-in-place disaster or post-disaster when SUD referral resources and step-down services may be diminished. Similarly, if a provider cannot

reach “x” level of SUD treatment hours due to disaster conditions, leeway should be given recognizing the extenuating circumstances.

DOJ settlement agreement requirements –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.

- ***Suggestion:*** N/A

Fraud, waste, and abuse initiatives –Please offer suggestions for changes that could be made in the new MCO contract that will strengthen FWA prevention, detection, and recovery efforts.

- ***Suggestion:*** *MCOs must annually train SUD providers on guidelines for audits and allowed/non-allowed activities so that providers have a full understanding of the rules and regulations pertaining to what constitutes fraud, waste and abuse.* These should also be standardized across the MCOs as much as possible.
- ***Suggestion:*** *Compliance standards and protocols should be clearly written, detailed and distributed to all SUD providers annually.* Providers should be notified electronically of any updates to compliance standards.

Health equity –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?

- ***Suggestion:*** *Develop consistent, standardized authorizations across MCOs*. Approved treatment stays vary vastly across MCOs and even by enrollee’s substance of choice. This creates an unstable system where providers have no consistency for client’s approved length of stay and required repeated calls for reauthorizations for certain clients. These inconsistencies are not established in any best practices or even explained to providers, often it seems at the complete discrepancy (and sometimes personal bias) of the authorization representative.
- ***Suggestion:*** *Standardized length of stay for levels of care.* Length of stay should be based on best practices and clinical outcomes, not on inconsistent, bias-based factors such as an enrollee’s substance of choice or past treatment stays. Additionally, being approved for partial stays adds unnecessary administrative work for both providers and MCOs. Standard stays based on level of care removes bias and disparities from the equation and places all enrollees on an even treatment level. Suggested standard lengths of stay:
  - ***ASAM 3.7/ Detox:*** 4-7 days (Some MCOs will only give 3 days regardless of drug of choice, which leads to swift relapse)
  - ***ASAM 3.5/ Inpatient Residential:*** 28 days minimum, with option to extend to 90 days (Some MCOs only offer 3 to 15 days at a time)
  - ***ASAM 2.1/ Intensive Outpatient:*** 120-150 hours minimum, with option to extend to 312 hours (Some MCO try to keep services under 120 hours and SUD providers have to fight for additional hours).
- ***Suggestion:*** *MCOs should provide authorization and a response to denials/appeals within 24 hours.* SUD providers should not be providing services without the guarantee that they will be paid for services rendered.

Increased MCO accountability – Please offer suggestions for how can LDH hold the MCOs accountable for statewide policy, operational, and financial priorities in the MCO contract.

- ***Suggestion:*** *MCOs should be evaluated on how long enrollees engage in SUD treatment and how they step-down into levels of SUD care (i.e. from ASAM 3.7 to ASAM 3.5).* MCOs should be engaged in enrollee's treatment process and not simply a third-party gatekeeper. Evaluating and comparing how long MCOs keep enrollees in treatment and comparing the outcomes will highlight what MCOs prioritizing client care.
- ***Suggestion:*** *The State should develop a standardized process for providers to arbitrate disputes with MCOs and to report MCOS not following rules.* Currently, SUD providers have very limited recourse to hold MCOs accountable and are typically only able to wait for a resolution with that MCO's liaison, which puts providers at a marked disadvantage. The State should establish an impartial committee that can evaluate, provide mediation or rule on major disputes between MCOs and providers.
- ***Suggestion:*** *MCOs should face financial penalties for holding approved payments from providers for over 60 days. Prompt payment for services rendered should be standard*. If there is a rationale for withholding payments more than 60 days, providers should be notified in writing of the disputed billings and steps that can be taken to rectify the situation. MCOs that withhold payments with no written rationale that follows established protocols should be fined by the State.
- ***Suggestion:*** *MCOs should be required to provide written, electronic communication of relevant and pertinent information and changes to all providers.* This communication should be time-stamped and distributed widely to relevant parties and additionally posted on shared information boards that are clearly identified/updated for providers. Currently, MCOs often "alert" providers to important changes or communication via standard fax, an outdated technology that has no guarantee of concrete receipt. MCOs should be held accountable to be proactive on communication with providers.
- ***Suggestion:*** *Electronic portal access should be a standard, primary form of business.* MCOs should be held accountable to ensure their electronic portals are fully operational for providers. Currently, MCOs arbitrarily close shutdown their portals with no advanced notice, which forces providers to move authorizations to telephone systems, which delays the process and creates less accountability for the authorization representative because there is no electronic record of the providers requests. Business operations are much more accountable and reliable via electronic methods (such as portals) that can be tracked and time-stamped.

We thank you for the opportunity to submit this feedback and hope to remain included in the process moving forward.