Impact of Managed Care Transition on Behavioral Health Providers

Health and Human Resources Joint Oversight Committee
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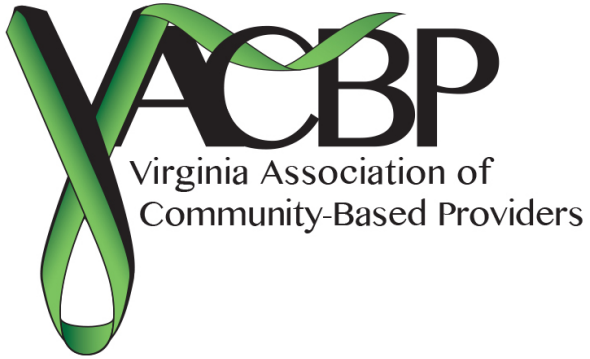

Background on the VACBP

- An association of *private-sector* organizations that provide *community-based* behavioral health and substance use disorder treatment to Virginia's most vulnerable populations, founded in 2013.
- *Among largest associations* representing the interests of private-sector behavioral health providers In Virginia, with more than 50 agencies that have more than 160 facilities across the Commonwealth.
- Members range from providers with *less than 10 employees to more than 500*, from agencies with one location to more than 30, serving the behavioral health needs of individuals in *all regions of the Commonwealth*.

VACBP
Virginia Association of Community-Based Providers

VACBP Provider Input on MCO Relationship

- Information gathered for DMAS MCO Resolution Panel.
- Goals:
  - *Identify areas of concern by MCO.*
  - *Determine where identified issues are trends as opposed to isolated incidents.*
  - *Identify what's working well and where improvement is needed.*
  - *Support development of potential solutions.*
- Surveyed members between January 1, 2021, and February 1, 2021.
- Topics identified were based on issues raised by members since the transition to managed care began.
- Included an opportunity for other comments.

Range of issues members could select

Challenging to resolve issues that arise
Consistently approving fewer units and/or shorter durations
COVID-19 not adequately factored into service authorization decisions
Lack of understanding of services by decision makers
Care coordinators and service authorization decision makers not in sync
Inconsistent/unclear business practices
Significantly increased administrative processes
Paperwork often lost
Short, unreasonable turn-around times to return phone calls/response to requests for information
Categorization of service authorization requests as urgent/not urgent
Inconsistent compliance with NCQA response times
Challenges with appeals process
Challenges with credentialing
Portal challenges
Challenges with MCO staff being respectful

Survey Findings – What's Working

- Appropriately categorizing service authorization requests as urgent versus not urgent.
- Consistently in compliance with the NCQA response time when responding to service authorization requests.
- No significant issues with credentialing.
- No significant issues with the amount of time given to respond to requests for information and to return phone calls.
- In most cases, MCO staff are being respectful when communicating with our members.

Where Improvement is Needed

- Fewer units and/or shorter duration for services than recommended.
  - *Issue with all the Medicaid MCOs except Aetna.*
  - *Particularly challenging with MHSS, IIH and TDT.*
- The manner in which the MCOs are considering the impacts of COVID-19.
- Care coordinators and service authorization decision makers are often out of sync.

Where Improvement is Needed

- Inconsistent/unclear business practices.
  - *Issue with all the MCOs except for Aetna.*
- Significantly increased administrative requirements.
  - *Issue for all the MCOs except for Aetna and Optima.*
- Portal issues a challenge for all the MCOs at some level.

Proposed Solutions/Improvements

- Provide clarity to the MCOs and providers regarding how the pandemic should or should not impact service authorizations.

- Provide joint training on Medicaid services, including eligibility, medical necessity criteria, how the service is intended to be provided, long- or short-term nature of the service.
  - *Should include providers, care coordinators and MCO SA decision makers to ensure consistent understanding.*
  - *This can also identify where the MCOs may be going beyond what is required in authorizing services.*

Proposed Solutions/Improvements

- Provide training on clinical documentation to better align expectations between DMAS, the MCOs and providers.

- Issue guidance clarifying those administrative processes and procedures that are required to be consistent among all MCOs and identifying where the MCOs have flexibility to work outside of these required administrative procedures.
  - *This can increase understanding with respect to what is required and what is not from an administrative standpoint.*

Proposed Solutions/Improvements

- Identify where forms and processes may be standardized for all MCOs and/or request that the MCOs work with one another to standardize forms that are used by providers.

- Consider areas where businesses processes (beyond forms) can be standardized for all the MCOs while not eliminating their ability to operate as they would wish in the areas that may be mission critical.

MCO-Specific Feedback Also Provided

Positives	Negatives
• **Positive working relationship** • **Able to easily resolve challenges that arise** • **Lack of understanding of services by decision makers is not often an issue** • **Inconsistent/unclear business practices are not often an issue** • **Increased administrative processes are not often an issue** • **Paperwork not often lost** • **Don't often provide short, unreasonable turn-around times to return phone calls/response to requests for information** • **Appropriately categorizing service authorization requests as urgent/not urgent** • **Not consistently out of compliance with NCQA response times** • **Appeals process is not often a challenge** • **Disrespectful staff is not often a problem**	• Long wait times on phone calls (19% of respondents) • Frequently transferred from person to person when communicating via phone (19% of respondents)
Feedback evenly split	
• **Consistently approving fewer units and/or shorter durations** • **COVID-19 not adequately factored into service authorization decisions** • **Care coordinators and service authorization decision makers not in sync** • **Portal consistency, efficiency, functionality and/or reliability is a challenge**	
Communications	
• **Vast majority of communication via fax (both to and from providers)**	

MCO Networks/Provider Terminations

We understand that **network management is foundational** to managed care.

Increased **transparency** is needed.

Patient choice is critical to patient engagement in treatment and positive health outcomes.

The Medicaid provider network should reflect the **diversity** of those they serve.

Some **oversight** of MCO network composition is needed.

MCO Networks/Provider Terminations

Solutions proposed include:

- Provide additional information about what each MCO evaluates as they identify providers they want in their network and those they do not.
- Establish a process by which MCOs provide feedback to a provider prior to terminating them from their network.
- Establish a process to enable providers that are terminated *without cause* can be re-considered for inclusion into the network at a later date.
- Provide oversight with respect to MCO network make-up to ensure patient choice is valued and the network reflects the diversity of those they serve.

MCO *Preferred* Provider Networks

- Providers want more information about how to be considered to be a part of these programs.
- There is a clear difference in the feedback shared between providers that are included in an MCO's preferred provider program and those that are not with respect to the administrative challenges providers are experiencing.

Project BRAVO

- Critical to ensure a comprehensive continuum of community-based Medicaid services that includes **prevention and early intervention** supports.
  - *Services today focus primarily on intensive treatment.*
  - *Patients must present serious symptoms in order to receive service.*
  - *Being exposed to trauma isn't enough.*

- **Recovery/maintenance services** are needed to minimize repeated need for more costly intensive treatment.
  - *Serious Mental Illness (SMI) is a chronic illness, like heart disease or diabetes.*
  - *Longer term, maintenance-focused supports are needed.*

Project BRAVO

- Provide **increased reimbursement rates** that more appropriately account for costs for the first time in more than two decades for most services.
  - *Current rates do not account for inflation, additional administrative requirements, increased cost to do business.*
  - *Stagnant reimbursement rates are the most significant factor creating the behavioral health workforce challenge.*

Project BRAVO

- Comprehensive consideration of the **layers of regulatory requirements** on providers is needed.
  - *With evidence-based services, important to ensure Virginia's requirements are aligned with the service developers.*
  - *Consideration of the additional training, oversight by the service developers, reporting, surveys, and the like is needed to reduce layers of duplicative regulatory requirements that may not be needed.*
  - *With accreditation requirements, a reduced/expedited licensing process should be considered.*

School-Based Services: The Challenges

- COVID has exacerbated behavioral health needs for children and adolescents.
- Therapeutic Day Treatment (TDT) is inadequate to meet the needs.
  - *There is no early intervention or prevention-focused Medicaid service that can be provided in the schools.*
  - *MCOs are approving fewer units and shorter durations of care than needed (for TDT).*
  - *Fewer and fewer providers are offering TDT.*
- Enhancement of school-based services must begin ASAP but additional supports are needed for kids now.

School-based Services: Possible Solutions

- Provide the resources and funding needed to enable DMAS to begin the **enhancement process for school-based services**.

- Consider a temporary **state-supported grant program** to provide a bridge between now and when school-based services can be redesigned.
  - *Focus on early intervention/prevention services to eliminate chance for overlap with TDT.*
  - *Ensure outcomes and accountability measures are incorporated.*
  - *Use one-time funding to serve as bridge to enhancement.*

Questions/Discussion

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