Stakeholder Comments: What Should the Medicaid Mental Health Managed Care Request for Proposal (RFP) Include?

(Derived from a summary of stakeholder input via the Public Dialogue Forum 8/30/11 to help the department develop the RFP.)

1) **Participant Assessment and Eligibility--What is the best way to assess needs and determine eligibility?**

   Require the MCO to….

   - structure the new system such that the treatment provider is not the provider who determines the participant's program eligibility and performs the initial assessment.
   - structure the new system just like the current system in which the treatment provider is the provider who determines the participant's program eligibility and performs the initial assessment.
   - allow for presumptive Medicaid eligibility so that a person can receive immediate treatment.
   - clarify the "gatekeeping" role and ensure the public has access to this information.
   - provide services that target the transition from institutions to the community.
   - provide opportunities for the participant to get connected to services for the first time.
   - make use of the "medical home" treatment philosophy.
   - coordinate all care.
   - bundle payments for the assessment process.
   - design a transition from the current system to the new system that ensures a seamless re-enrollment process for participants.
   - invite participants to share in decision-making about themselves.
   - change the use of language: use more self-determination-based language (e.g., use "Wellness-Recovery Plans" instead of "treatment plans")
   - include the uninsured population from the beginning and make use of a sliding fee scale.
   - describe a very clear process/path for persons to access the MCO service array.

2) **Benefits --What services must be included?**

   Require the MCO to….

   - emphasize the management of care of an individual's whole health.
   - address issues when they're less severe and when the participant is motivated to change.
   - ensure timely crisis response.
   - re-define and re-design crisis services.

- develop a pilot project around managing the costs of provision of emergency services versus provision of prevention services.
- decrease the duplication that is present in the current system through the coordination and consolidation of services.
- provide for mental health check-up services that will allow for screenings to occur in clinical settings with less and less frequency, with some level of screening being administered by the family for their own family member.
- Give participants incentives to set their own wellness goals.
- provide services that must be community-based and recovery oriented.
- make services available where people live: their homes, schools, and communities.
- clearly define medical necessity and make it easily available to everyone.
- clearly define services and ensure participants have easy access to them.
- include services that target people with DD/MH dual diagnoses.
- expand the continuum of care.
- use cutting edge practices to decrease costs rather than providing only the services currently available.
- recognize and use alternatives to evidence-based practices.
- emphasize helping people have better lives not just treating mental illness.
- provide for trauma-informed care.
- create services that honor participants and trauma survivors.
- provide options for self-determination and choice.
- provide recovery planning opportunities.
- include the following services: Peer-run respite, peer-provided crisis intervention, mobile crisis response, hospital diversion, hospital services, ACT, residential treatment, safe houses, recovery renovations, wellness-recovery action planning, collateral contact, follow-up care, and long-term case management for serious disorders
- provide focused case management especially for those participants with chronic and severe medical and behavioral conditions.
- adhere to certain limitations on hospital usage and suffer penalties for exceeding the limitation.
- include enhanced services beyond the core services.
- provide for agencies that operate beyond regular business hours.
- provide a modern pharmacy benefit that is carefully crafted and adequate.
- provide open access to mental health medications.

- offer integrated mental health and substance use disorder services.
- develop a mechanism for linkage to out-of-system services and back again.
- provide financial incentives for providers serving participants with the most complex treatment needs.
- make use of telehealth technology.
- design creative alternatives to service delivery in rural and frontier areas.

3) Provider Qualifications and System Delivery Standards--Who should be able to provide services and what standards should be established?

Require the MCO to…

- provide education & training to increase provider capacity and to create a well-trained work-force.
- work with universities to help develop the needed workforce.
- develop enough of a competent workforce so that participants' have a choice of providers.
- provide ongoing education for the workforce.
- help achieve compliance to new law for national accreditation over time in a way that it doesn't create a barrier for participants accessing services.
- aspire to a higher level of quality of provider performance than the minimum standards required by licensure or national accreditation.
- reimburse adequately to support a qualified workforce.
- measure providers' performance by comparing them to each other (similar to HEDIS methods).
- incorporate psychologists as well as psychiatrists.
- allow a provider type that is exclusively for assessment services.
- ensure adequate access to all services in all areas of Idaho.
- incentivize care so that eventually dollars that are spent on acute care services can be shifted to prevention efforts and lower levels of care.
- make use of peer specialists.
- accommodate geographic areas that have professional shortages.
- use local providers.
- make maximum use of the existing workforce.
- make use of lower credentialed members of the workforce to perform more work that is then overseen by higher credentialed members of the workforce so the scarcer resources are supported.

- adhere to professional standards of practice for determining appropriate staffing patterns.
- provide incentives for professionals to work in rural areas.
- provide incentives for professionals according to their credentials for greater retention.

4) Quality Assurance(QA) --What data should the managed care entity provide regarding outcomes?

Require the MCO to…

- make QA a priority.
- create data reports that will be useful and transparent to all stakeholders, especially the department and the Idaho legislature.
- focus on quality of care while also collecting minimally necessary QA data about critical issues.
- ensure all administrative requirements translate directly into an added value for participants.
- ensure shorter waiting times for the first appointments following hospitalization.
- make MCO QA data available to the public.
- pay for performance.
- reinvest earnings; define the medical loss ratio and then direct a percentage of profits back into programming.
- set benchmarks.
- allow participants to set benchmarks.
- measure the impact of services by monitoring the outcomes.
- use CAFAS data to measure children's outcomes.
- ensure "cherry picking" doesn't occur—that is, provider agencies selecting only those participants with the least intense service needs to work with.
- simplify and refine the current system.
- hire a third-party person to perform QA.
- pay for independent evaluations of the MCO's performance.
- use participants to evaluate programs.
- use participants to define the success of treatment.
- use participant-designed satisfaction surveys.
- be responsive to participants' quality of life.
- use focus groups for input.

- ensure all services are culturally sensitive including the use of language.
- follow participants who drop out of treatment to determine/track why they dropped out.
- ensure any gaps in service delivery are identified, measured, and reported on.
- create reports reflecting treatment encounters as well as additional utilization data.
- make use of qualitative data, the real stories behind the accumulated data that paint the picture of what real life is like for a participants.
- develop a detailed transition plan that is transparent to the public.

5) Local Community Engagement--How should the managed care entity work with local communities to address conflicts, complaints, and obtain feedback?

Require the MCO to:

- make the MCO's health plan practices transparent.
- reference other states' successes in implementation of a managed care system and service delivery of managed care services.
- clearly describe members' rights and responsibilities.
- communicate protocols.
- train providers and participants about how the new system works.
- ensure no disruption in services.
- consult with existing organizations (e.g. regional boards, Governor's Inter-Agency Cooperative, advocacy groups).
- educate community leaders.
- be visible in the community.
- make use of modern technology such as Web sites for communicating.
- be inclusive of participants' input at every level from prevention to hospitalization.
- establish community review boards that include families and participants in a complaint resolution process.
- develop a dispute resolution process to ensure immediate responses to denials, appeals, and grievances.
- use peers and families as advisors and subject matter experts.
- designate a liaison to SPCMH.
- designate specific staff to liaison with participants.
- provide liaisons to all the MCO customers (e.g., courts, corrections, schools, local medical communities, FQHCs) and provide opportunities for their input.

- work collaboratively with all service providers so that efforts are coordinated.
- work with established systems for health information exchange.
- establish systems and protocols for sharing health information 24/7.
- embrace Idaho “as it is” and work to develop the infrastructure necessary to share health information.