From: SCOTT MAYNE [mailto:scottmayne@sbcglobal.net]
Sent: Tuesday, January 12, 2016 8:35 AM
To: Jane Gruner
Cc: SCOTT MAYNE; SCOTT MAYNE; Frank Cervantes; Elizabeth Florez; Joe Haas; John "Jack" Martin; Patrick Schreiber; Brandi A. Johnson; Pam Fine; Cheryl Wright
Subject: Medicaid Managed Care Expansion Hearings

Hi Jane,
Good seeing you last week at the MCO meeting! Thanks for the opportunity to have input on the MCO expansion.

I would like to comment on those populations that I work with and my current and historical experience with the MCO environment.

For one, I am supportive of the MCO concept for service coordination and access. I believe this is important to identify needed and appropriate services for those individuals that do not have a service system or supports available to them.

Four basic areas come to mind that the MCO delivery system has not, and in most cases, cannot provide appropriate and timely services to or for. These are:

1) Case Management versus Care Management. This is an ongoing challenge in our Medicaid world of understanding that Care Management involves the tracking, coordination, and accessed to needed medical and mental/behavioral health services and that Case Management involves the assessment of the individuals total needs including social, educational, medical, mental health, economic needs that are impacting the child and family. Where Care Management may do an assessment of need and then follow up to make sure the individual takes there medication, goes to their medical/mental health appointment, and maybe coordinate transportation, the Case Management process requires the Social Worker/Probation Officer to assess the needs of the individual and family, identify housing, community, and educational challenges and issues, in addition to insuring needed medical, mental health, medication, and person of legal responsibility, as well as coordinate the legal needs and aspect of that individuals life and circumstance. Case Management involves the coordination and access to services for that individuals entire life and not just the medical and mental health needs. Medicaid and the MCOs need to recognize that Case Management Services are non-medical services that Federal Guidelines recognize as need to assisting the eligible individual in accessing and coordinating needed social, economic, educational as well as medical and mental/behavioral health needed services. It, in its self, is not just a medical model service.

2) Juvenile Justice and Child Welfare need to immediate access to screening, assessment, medications, and therapy. Current practice and historical experience shows that the MCOs have not and do not staff to meet the need of children and youth in crisis and short-term intervention. Most times there is a multi-month wait to see a clinician, psychologist, or psychiatrist through MCOs. As noted in the recent Provider Access Analysis done by Medicaid there is serious access issues for the specialty services under the MCOs. Either the providers are no longer associated to the MCO, or they do not take more Medicaid clients, or they do not allow timely appointment and services. I would strongly suggest that these, the results of the Provider Access Reports, are

all examples for the normal population to access services and not the enhanced need for those in crisis in the Child Welfare or Juvenile Service environments. That is why all Child Welfare and Juvenile Justices agencies have clinical staff as employees. The system has forced the counties to have these staff because Medicaid does not have the provider network with child behavioral health experience or the ability to timely and appropriately serve the population. Absolutely there needs to be a coordination and transitioning of services to the MCO or community services once the circumstance stabilizes. It is many times, more likely that the transition needs to be with the Care Management entity and not a MCO because of the high needs of the individual. When I hear that you are looking at rolling the CW and JJ population under the MCOs I hope it is for timely, appropriate, and trained medical and mental health services but not attempting to replace the comprehensive case management that is being provided already by trained liecnsed Social Workers and Probation Officers.

3) The Case Management ability of the MCOs is limited to those they may know are Medicaid eligible and are using their services. In both the children's and senior population many of the individuals who do not yet rise to the level of abuse and neglect (seniors or children) or long-term care are poorly served by Medicaid and usually not at all by the MCO system. In the Senior population many of the individuals that access the Senior Services programs, such as Meals on Wheels, have social services needs that go beyond getting just a meal. They are not accessing Medicaid or the health care system until they are placed in LTC. An example of this is the County Match Program where the Counties pay for LTC placements for individuals who have not seen a Social Worker, have not received services that may be available to divert or delay them them from LTC. The Medicaid/SSI eligibility system and process is too complex, not reasonably available to them, or is deemed as a welfare system that they view as a handout.

In the children's environment we investigate for abuse and neglect and youth offender issues, identify that the child and family's issues do not rise to that level, refer the child to non-profit community providers who are unable to get reimbursement for, some programs up to 80% Medicaid eligible children, otherwise allowable coordination of services in the community that again the MCOs do not support. MCOs want to do Care Management not Case Management. Medicaid and the MCOs do not want to recognize there is a need for comprehensive case management that goes further than medical/mental health services.

4) Many times children come back out of the Child Welfare and Juvenile Services systems but lose their Medicaid eligibility, and therefore Medicaid, Mental Health services, and continued access to needed medications because their families do not follow up with the complex and intimidation eligibility process once the child is sent home. Again, the MCOs do not see or support this population. Still, we see in the Child Welfare and Juvenile Services population only 20-30% of the population being serviced in their home having insurance (private, Medicaid, or Nevada Checkup). In reviewing of these families demographics for a 3 month period, 65% - 85% should have been Medicaid or Nevada Checkup eligible.This population is not being supported by Medicaid or the MCOs. 60%+ of the Senior population served by Washoe County Senior Services should be Medicaid/SSI eligible but for those multiple reasons noted above do not get or follow through with getting eligible. Again, this population is not being seen by the system except at the ER level periodically.

Hopefully I have summarized some of my concerns with the current provision of services through the MCOs and Medicaid as well as my concern for the expansion of these MCO services to the senior, child and youth populations.

Please let me know if you have any questions.
Scott