BUILDING BLOCKS OF MANAGED CARE, PART 1:

CONTEXT AND FOUNDATIONAL ELEMENTS OF MANAGED CARE FOR BEHAVIORAL HEALTH

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
Josh Rubin, HMA

Tuesday,
May 9, 2023
9:30 am – 10:30 am ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

PLANNING FOR INTEGRATION: STATE EXAMPLES

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- DBH's contractor, the Aurrera Health Group, conducted a national review of strategies for integrating behavioral health services into managed care and interviewed five states with carve-in experience.
- Its summary report included four key lessons:
  - Support and train behavioral health providers early and often
  - Support provider stability and enrollee access to care
  - Ensure oversight of MCOs specific to behavioral health care
  - Build strong partnership b/t Medicaid and behavioral health teams

Aurrera Health Group. Strategies for Integrating Behavioral Health Services into Medicaid Managed Care Systems.

DHCF-DBH REQUEST FOR INFORMATION (RFI): MEDICAID BEHAVIORAL HEALTH TRANSFORMATION

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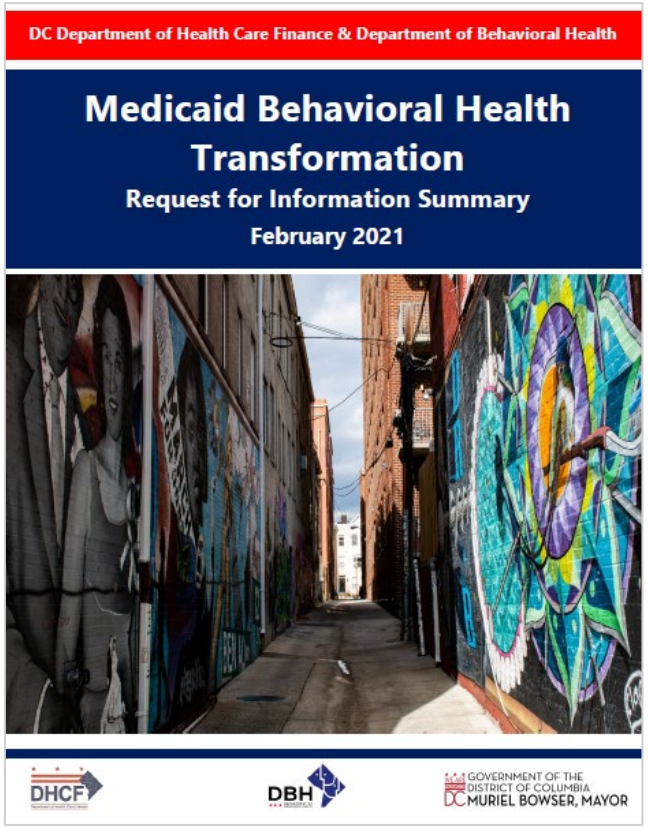
- Overall, respondents were supportive of transforming behavioral health care in the District to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is "comprehensive, coordinated, high quality, culturally competent, and equitable."
- Consensus noted in these areas (16 responses to 21 Qs):
  - Telehealth parity
  - Need for targeted interventions for special needs populations
  - Support for a community-based approach informed by SDOH
  - Funding and focus on improving health equity
  - Defining and measuring success of efforts to integrate care based on specific health outcomes.



DHCF and DBH. Medicaid Behavioral Health Transformation Request for Information Summary, February 2021.

DHCF-DBH: ASSESSING INDIVIDUAL PROVIDERS' NEEDS FOR TECHNICAL ASSISTANCE (TA)

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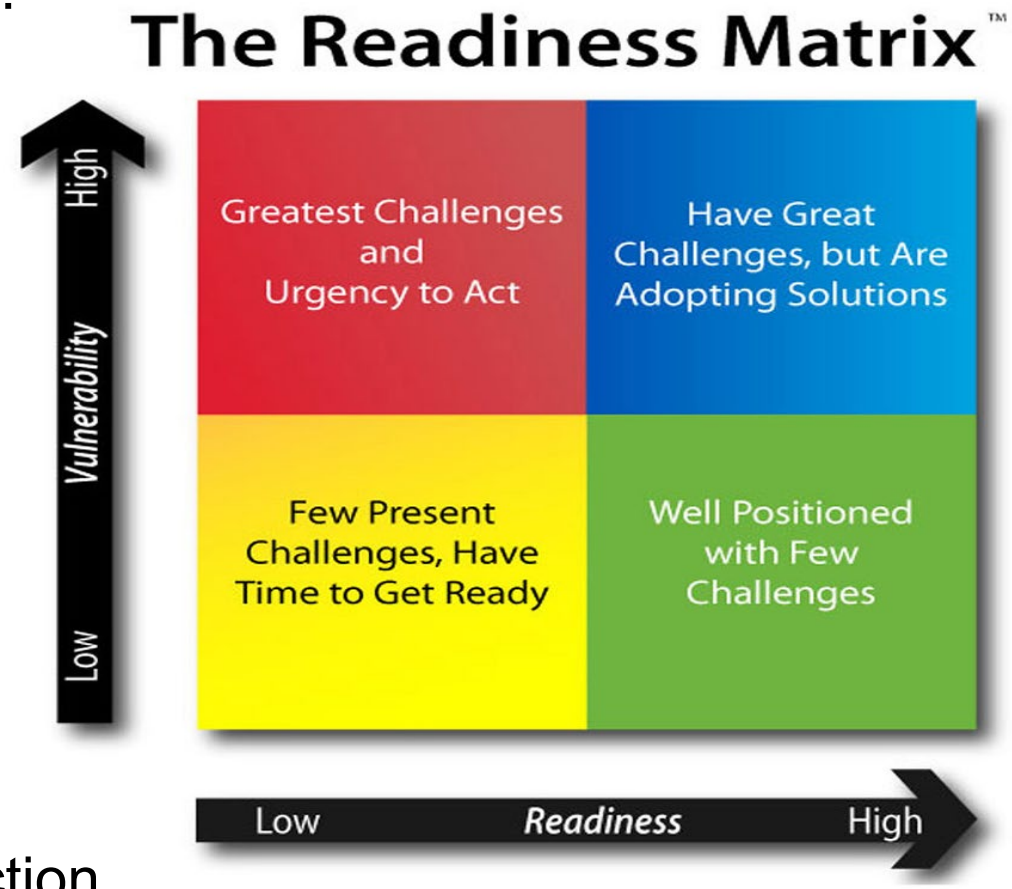
- Assessed the individual needs of providers using:
  - Provider Readiness Survey
  - Revenue Cycle Assessments
  - Provider Assessment on Integrated Care
- Designed the readiness process to:
  - Inform BH providers about the full spectrum of activities and capabilities required for managed care contracting; and to
  - Identify where BH provider organizations would benefit from TA to improve their practice to function effectively within the managed care framework.



Source: DBH Provider Mtg; Readiness 11/4/21

THE TRIPLE TO THE QUINTUPLE AIM

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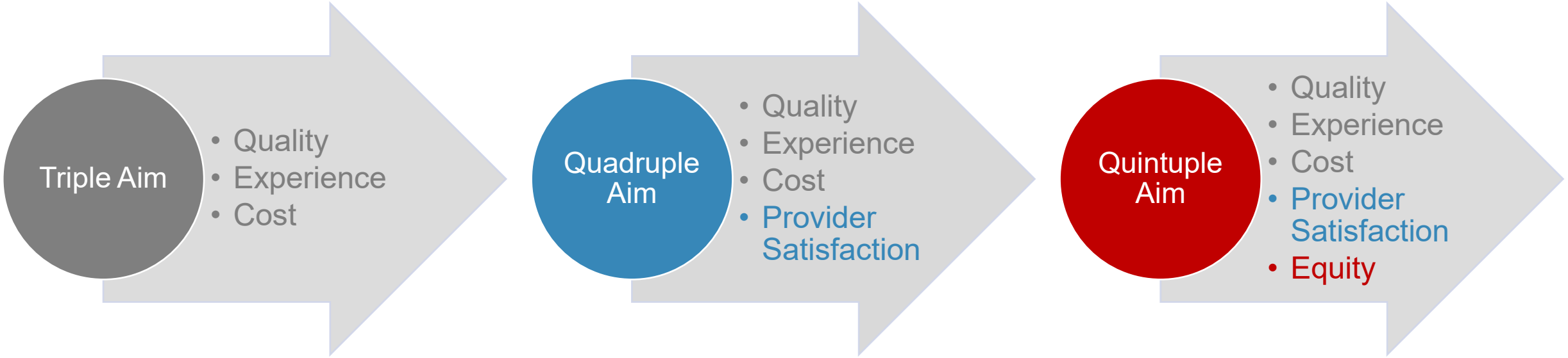

Source: Institute for Healthcare Improvement: www.ihi.org.
Bodenheimer T and Sinsky C, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Ann Fam Med 2014;12:573-576.
Coleman K., Wagner E., Schaefer J., Reid R., LeRoy L. Agency for Healthcare Research and Quality; 2016. Redefining Primary Care for the 21st Century. White Paper. (Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA under Contract No.290-2010-00004-I/ 290-32009-T.) AHRQ Publication No. 16(17)-0022-EF.

WHAT IMPACTS HEALTH OUTCOMES?

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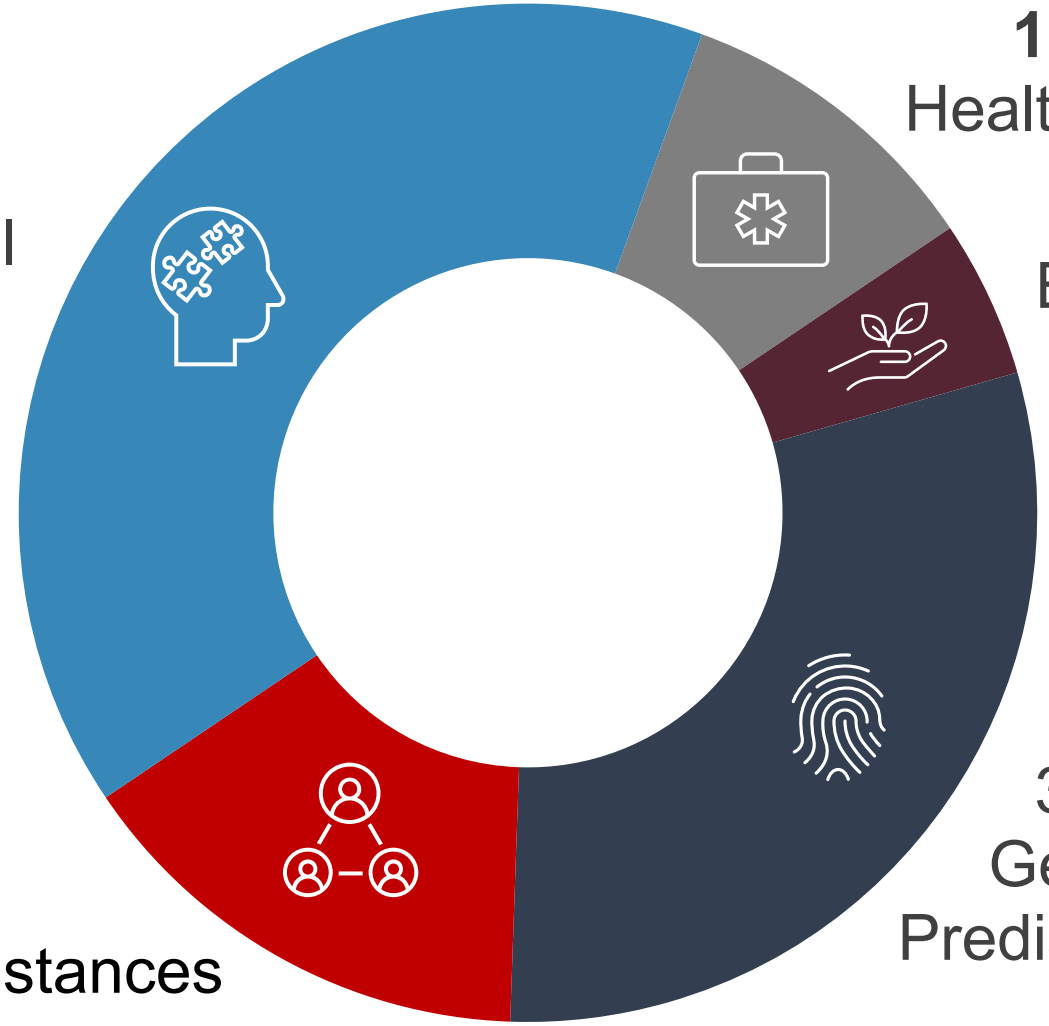

Source: Schroeder, Steven A. *We Can Do Better – Improving the Health of the American People*. N Engl J Med 2007;357:1221-8

A CONTINUUM-BASED FRAMEWORK FOR INTEGRATING CARE

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Case finding, screening, and referral	• Screening, initial assessment, and follow-up • Referral facilitation and tracking
Ongoing care management	• Coordination, communication, and longitudinal assessment
Information tracking and exchange	• Clinical registries for tracking and coordination • Sharing of treatment information

Source: Chung, et al. Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework. United Hospital Fund, 2016.

THE ROLE OF SPECIALTY BEHAVIORAL HEALTH IN AN INTEGRATED CARE ENVIRONMENT

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Coordinated		Co-Located		Integrated	
Level 1 Minimal Collaboration	Level 2 Basic Remote Collaboration	Level 3 Basic On-Site Collaboration	Level 4 Close On-Site Collaboration	Level 5 Approaching Integration	Level 6 Transformed Integrated Practice

The learning imperative for BH providers:

- to integrate into the ecosystem of providers that works with their clients
- to function more like traditional medical specialties

BH integration creates financial underpinnings to make this more possible.

Source: SAMHSA-HRSA Center For Integrated Health Solutions from The National Council for Mental Wellbeing (Accessed 4/27/2023). https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56.

INTEGRATION IMPROVES LIVES, REDUCES COSTS

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RETURN ON INVESTMENT

ROI of $6.50 for every $1 spend

CONTROLLED TRIALS DEMONSTRATE IT IS MORE EFFECTIVE AND EFFICIENT

70+ randomized controlled trials demonstrate it is both more effective and more cost-effective
+ Across practice settings
+ Across patient populations
+ For a wide range of the most common BH disorders

BETTER OUTCOMES

Better outcomes for common chronic medical diseases.

GREATER PROVIDER SATISFACTION

Sources: Unützer J et al. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013. https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. See also reference list at end of slide deck.

UNDERSTANDING BEHAVIORAL HEALTH INTEGRATION

FEE FOR SERVICE VERSUS MANAGED CARE

Fee for service

- DC bears the risk and uncertainty
- Incentive to overtreat
- Care is unmanaged
- Less ability to address health-related social needs
- No holistic view of the client
  - Especially problematic for people with multiple chronic conditions
- Individuals & providers as care managers

Managed care

- MCO bears the risk and uncertainty
- Incentive to keep healthy through preventative care
  - Establishes usual sources of care
- Promotes efficient use of services
- Network adequacy standards
- Quality assurance and improvement function
- External quality review required
- Aggregation structure to incent quality

Source: Medicaid and CHIP Payment and Access Commission, Managed care's effect on outcomes. www.macpac.gov/subtopic/managed-cares-effect-on-outcomes.

MANAGED CARE OUTCOMES

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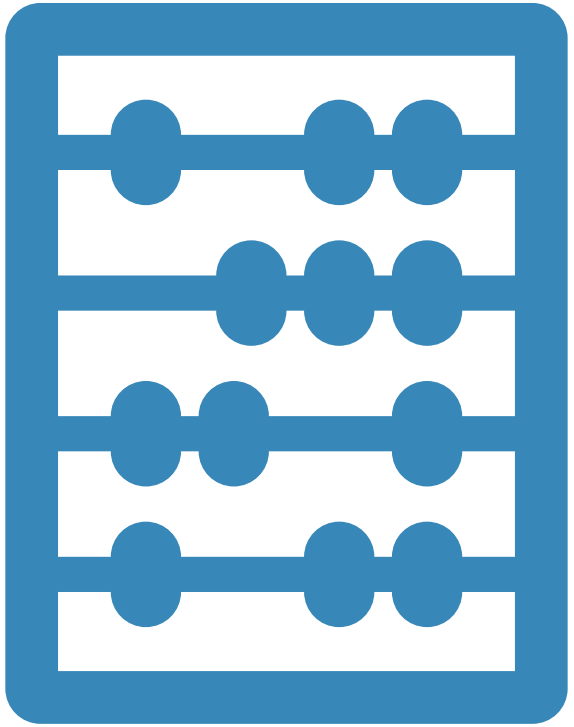
- Higher rates of preventative services utilization
- Reductions in inpatient procedures
  - Fewer inpatient complications
- Reduced mortality rates for specific populations
- Increased maternal care
- Higher patient satisfaction
- Reduced hospital costs



Source: Namburi, N., & Tadi, P. (2022). Managed care economics. In *StatPearls [Internet]*. StatPearls Publishing.

ALIGNING PAYMENT AND PRACTICE TRANSFORMATION FOR WHOLE-PERSON CARE

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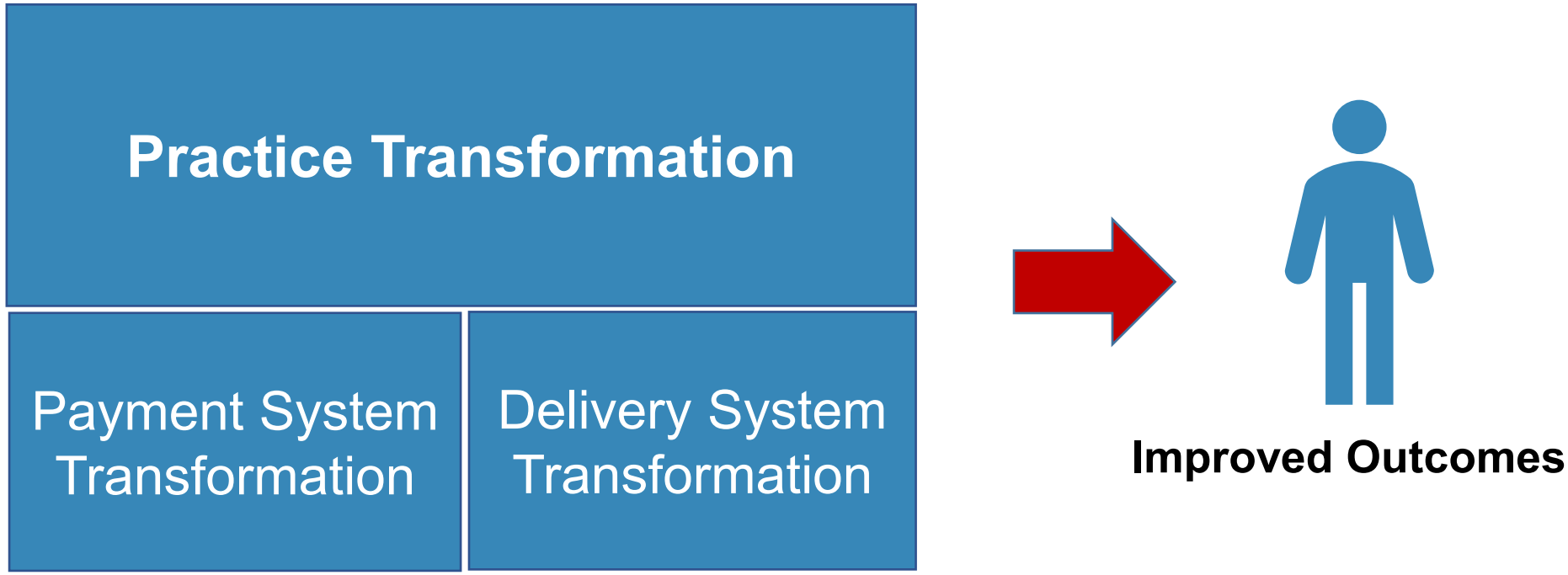
Delivery system transformation and payment system transformation create a financially sustainable model for practice transformation that improves patient outcomes.



MORE THAN 80% OF THE DISTRICT'S MEDICAID ENROLLEES ARE IN MANAGED CARE

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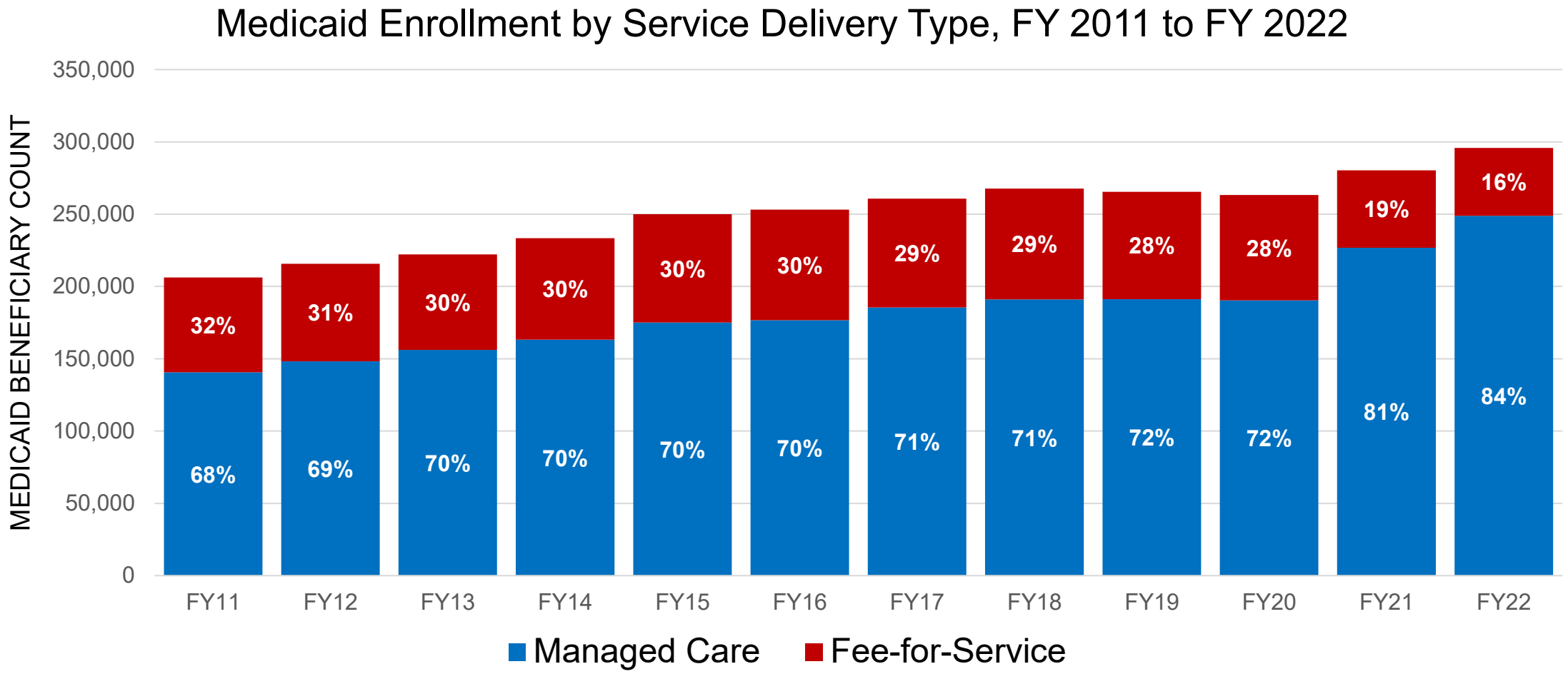

Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Enrollment reflects average monthly.

COMMUNITY BEHAVIORAL HEALTH: AN HISTORIC PERSPECTIVE

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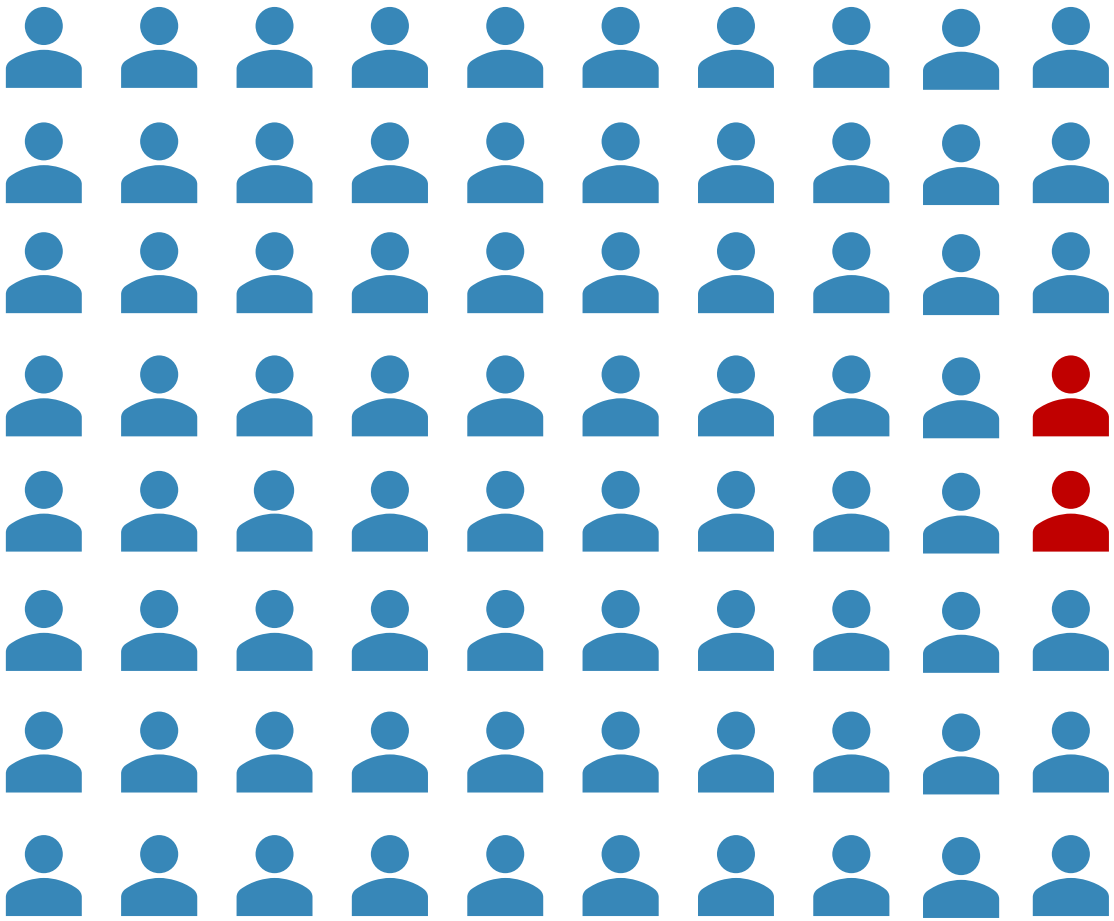
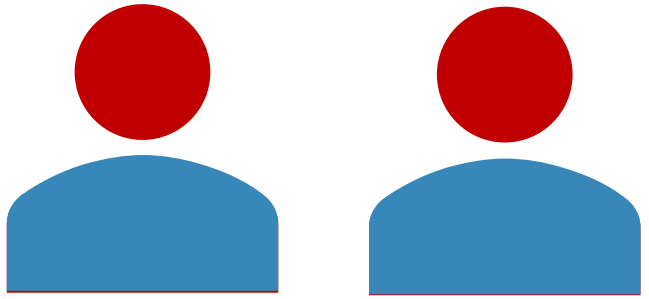
Served a small portion of the population



Only tended to a portion of their needs



BEHAVIORAL HEALTH (BH) ACCOUNTS FOR A DISPROPORTIONATE SHARE OF MEDICAID SPENDING

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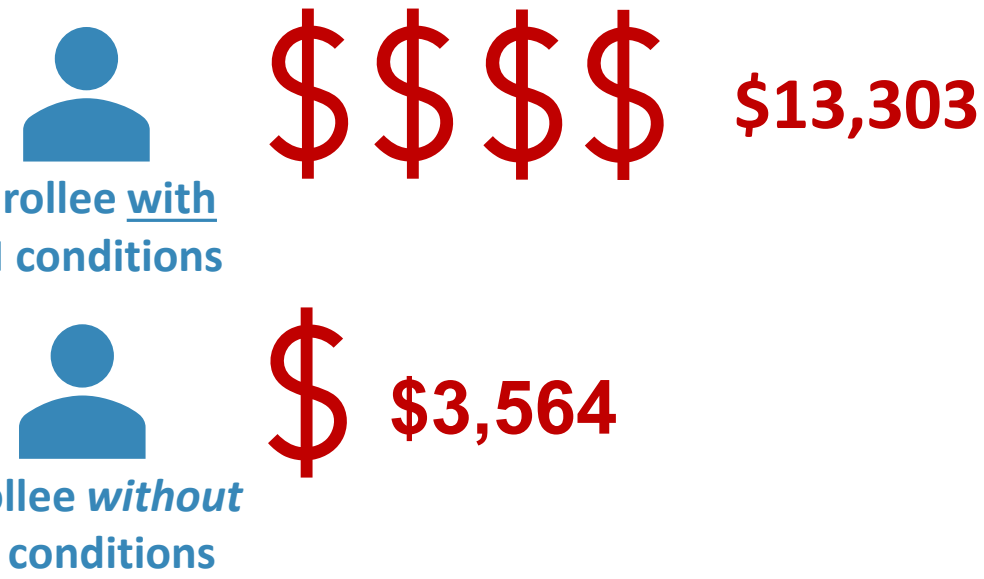
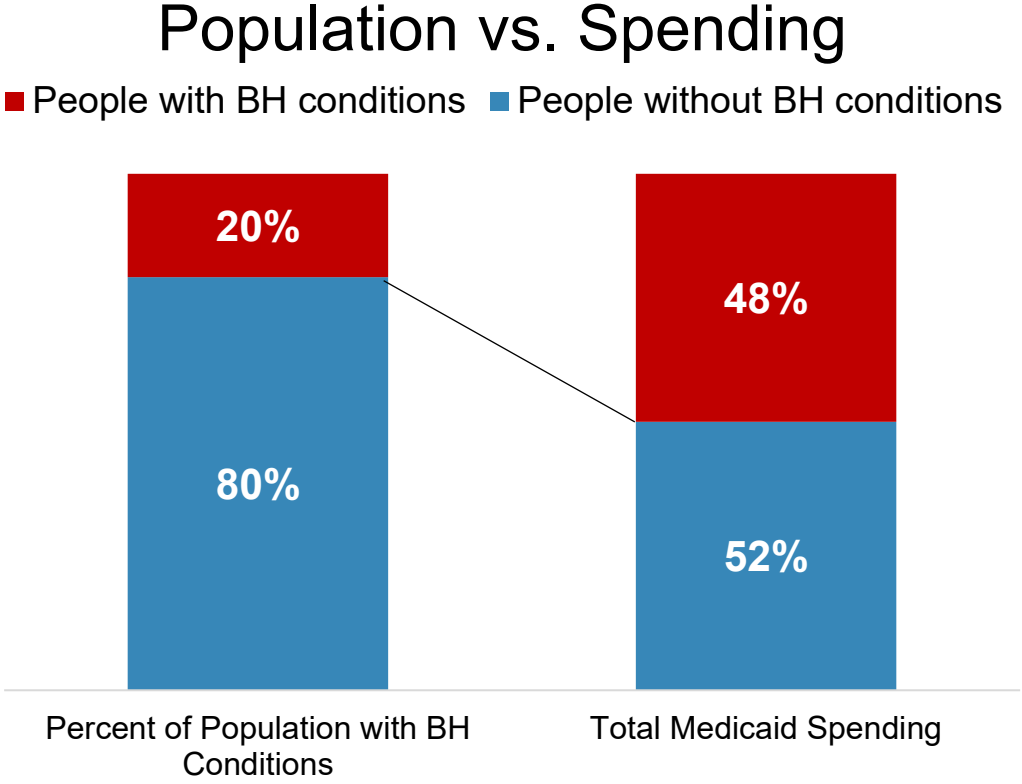
In the U.S., average Medicaid spending per enrollee with behavioral health conditions is nearly **four times** as much as for enrollees without these conditions.



Only 20% of Medicaid enrollees in U.S. have BH conditions, but nearly **half** of Medicaid spending is for enrollees with BH conditions



Source: Medicaid's Role in Behavioral Health, Henry J. Kaiser Family Foundation, May,2017. https://files.kff.org/attachment/Issue-Brief-Medicaids-Role-in-Financing-Behavioral-Health-Services-for-Low-Income-Individuals.

BEHAVIORAL HEALTH INTEGRATION: FROM CARVE OUT TO CARVE IN

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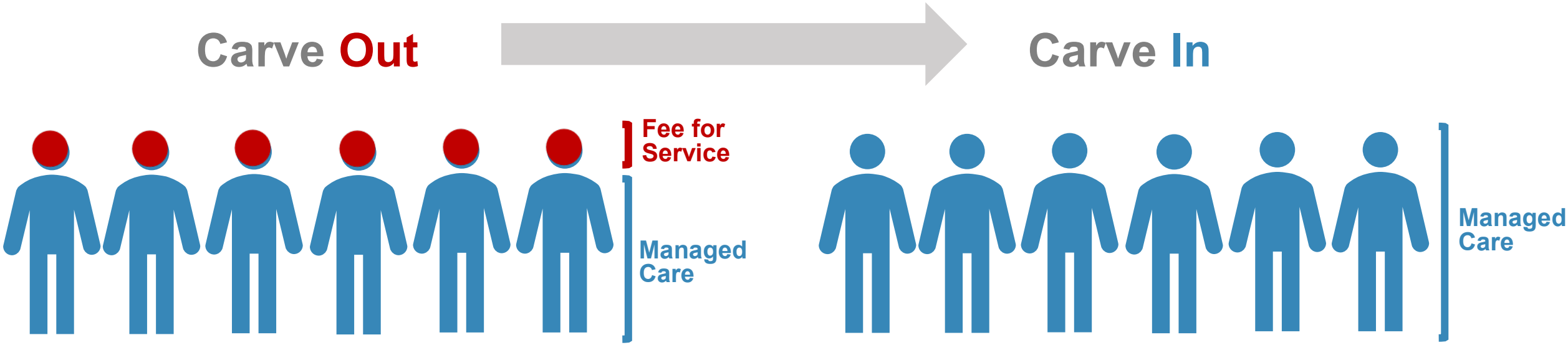

Separate payment methodologies for different parts of the body make whole-person care difficult

A CRITICAL PIECE TO REMEMBER

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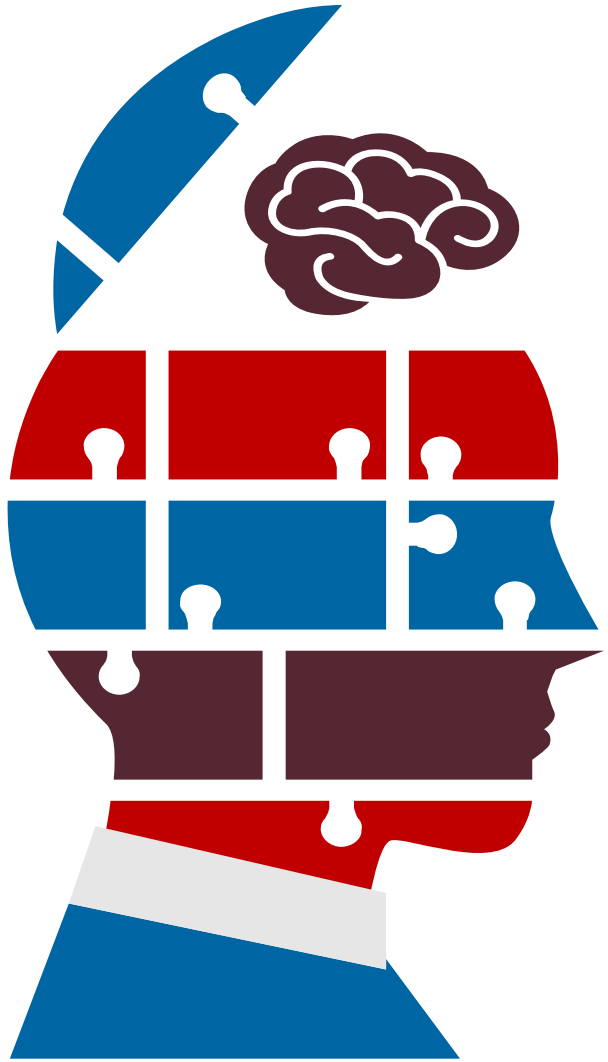

Integrated funding

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Integrated care

YOUR RELATIONSHIP WITH THE MCO AS THE PAYER

IMPACTED PROVIDERS AND SERVICES

THE MAJOR STRUCTURAL CHANGE

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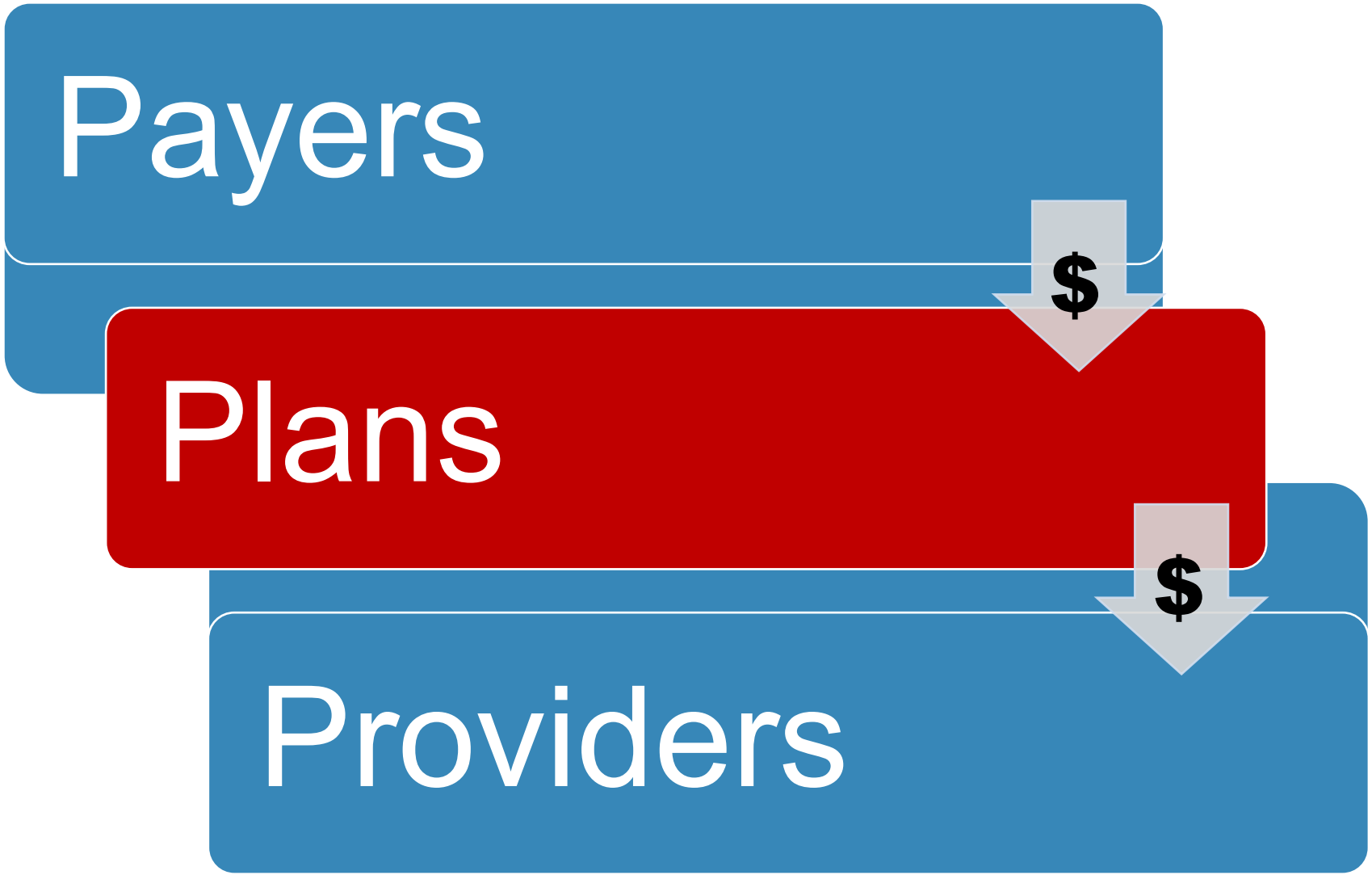

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DC Healthcare Alliance Program participants will have full coverage for mental health and substance use disorder assessment and treatment

DC BEHAVIORAL HEALTH INTEGRATION UPDATES: IMPACTED PROVIDERS AND SERVICES

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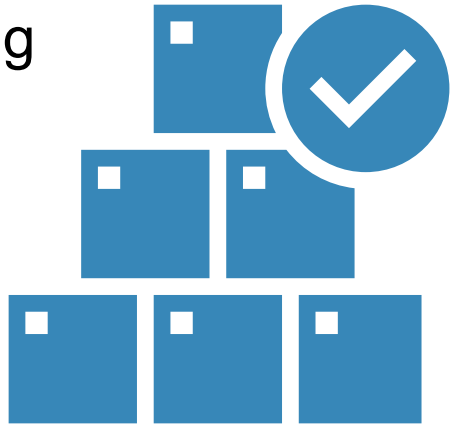
- DBH requires all DBH Certified Providers to contract with each Managed Care Organization (MCO)
  - Fosters beneficiary choice of provider regardless of health plan
  - Facilitates smooth transition process; can retain current provider
  - Ensures providers are preparing as required
- The health plans are no longer allowed to sub-contract Care Coordination and Case Management services

FOUNDATIONAL ELEMENTS OF MANAGED CARE FOR BEHAVIORAL HEALTH

FOUNDATIONAL ELEMENTS OF MANAGED CARE

Key foundational elements include:

- Managed Care Terminology
- Utilization Review & Utilization Management
- Authorization Process
- MCO Priorities (incl. direct input from MCOs)
- Enrollment
- Payment Constructs and Value-Based Payments
  - Capitation (full and partial)
  - Diagnosis-Related Groups
- Contracting
- Quality Improvement vs. Quality Assurance (QI vs. QA)
- Analytics
- National Provider Identifier (NPI)
- Credentialing



MCO PRIORITIES AND REQUIREMENTS

DHCF'S PRIORITIES REFLECTED IN MCO CONTRACTS

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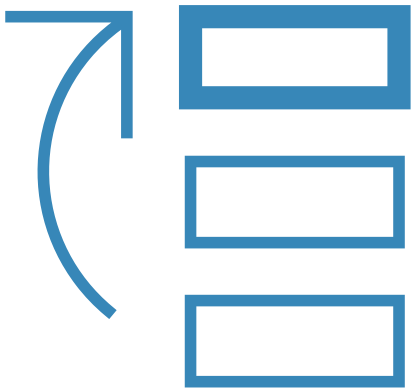
- As DHCF continues to move towards a fully managed Medicaid program, it seeks to transform the managed care program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.
- The provisions of the solicitation for the three MCO contracts that went into effect in the District on April 1, 2023 reflect DHCF's vision, mission, and strategic priorities.
- Behavioral health providers who want do business with the DC Medicaid MCOs will benefit from increasing their understanding of the priorities of both the DC Medicaid managed care program and the individual MCOs operating under contract to DHCF.

MCO PRIORITIES



- Quality monitoring and reporting
- Manage Care
  - Improved health outcomes for members
  - Timely access to high quality services for members
- Manage Costs
  - PMPM
  - Administrative
- Adequate Network
- Authorization
- Utilization Management
- Customer Service
  - Members
  - Funders/regulators (DHCF, CMS)
  - Providers

HOW MCOS MANAGE COSTS

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- Preventive care for chronic conditions
  - Primary prevention: prevent
  - Secondary prevention: detect and treat early
  - Tertiary prevention: disease management
- Lifestyle changes
- Care management to ensure efficient use of healthcare resources
- Care coordination to enable team-based care across providers
- Data analysis to identify inappropriate utilization

CUSTOMER SERVICE STANDARDS

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- Each MCO is required to provide an enrollee handbook
  - Benefits provided (amount, duration and scope)
  - How and where to access benefits, including transportation
  - Procedures for obtaining benefits
    - Requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the PCP
  - After-hours and emergency coverage
  - Beneficiary rights and responsibilities
  - How to select or change PCP
  - Grievance, appeal, and State fair hearing procedures and timeframes;
  - Toll-free telephone contact information
    - How to access auxiliary aids and services, including alternative formats or languages
  - Information on how to report suspected fraud or abuse.
- Provider network directory in a format specified by DHCF

THE MCO CONTRACT IS THE MECHANISM FOR ACCOUNTABILITY FOR BOTH MCO AND PROVIDER

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- Parties and definitions
- Scope of services
- Payment adjustments
- Administrative requirements
- Indemnification
- Compliance
- Term and termination
- Representations and warranties
- Assignment
- Amendment
- Notices
- Dispute resolution or litigation
- Audits, monitoring and oversight

DC ACCESS: 4 STANDARDS

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- Time and Distance Standards
- Timely Access Standards (i.e., appointment wait times)
- Provider to Enrollee Ratio:
  - 1 PCP for every 500 Enrollees (Adults)
  - 1 PCP for every 500 Enrollees (Children and Adolescent) thru age 20
  - 1 Dentist for every 750 (Children and Adolescent)
- Language and Cultural Competency Accessibility

Appointment Wait Time Standards

Provider Type	Appointment Type	Wait Time
Primary Care	New Enrollee Appointment	45 days of enrollment
	Routine Appointment	30 days of Enrollee Request
	Well – Health for Adults 21+	30 days
	Non-Urgent Referrals	30 days
	Diagnosis and Treatment of Health Condition (*not urgent*)	30 days
Specialists	Non-Urgent Referral	30 days
Pediatrics (EPSDT)	New Enrollee Appointment	60 days
	EPSDT Examination	30 days
	IDEA	30 days
	IDEA Treatment	25 days with IFSP

Source: DHCF. MCO Provider Network Management. MCAC Access Subcommittee Meeting (January 13, 2021).
https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/2021%20Provider%20Relations%20Network%20Requirements%20ppt3-%20MCAC%20Subcommittee%20Mtg%20Jan%2012.pdf.

PARTNERING WITH MANAGED CARE

PROVIDER-PLAN COMMUNICATION

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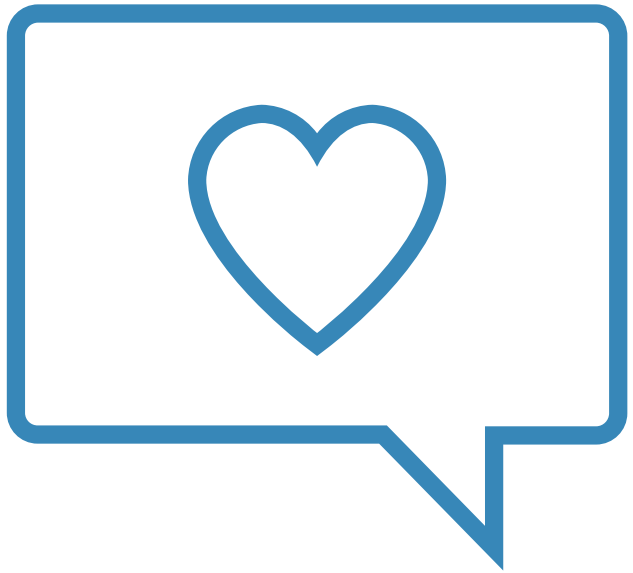
- Plans are part of the patient-centered planning team
- Knowing **who** to contact and **when** is key to smooth collaboration and getting issues resolved
- Some of the plan communication processes and protocols are set by the District; others vary by plan
- Designate a **liaison** responsible for developing relationships with plan contacts



LIAISON ROLE

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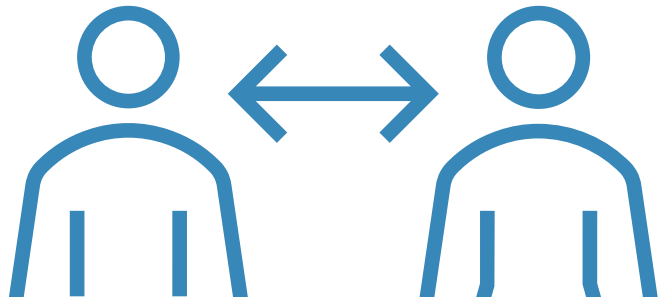
- Know the policies for communicating with and reporting to plans regarding member verification, service authorization, etc.
- Become familiar with plan resources and materials:
  - **Provider manual:** Includes all relevant information on BH services, BH-specific provider requirements
  - **Plan websites:** Contain resources and information



- Keep a record of important plan phone numbers & contacts
  - A telephone tracking log is a good idea
- Track plan reporting and information submission requirements (e.g., for performance reporting) and ensure they are being met

COMMUNICATING WITH THE PLAN

COORDINATING THE PRACTICE-BASED CARE MANAGEMENT AND MCO OUTREACH

CREATING A SUCCESSFUL CARE MANAGEMENT (CM) PROGRAM

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Seven building blocks to care management

- Joint planning with network providers
- Integrated evidence-based CM
- CM staff working at top of license
- Bidirectional interoperable communication
- Daily analytics monitoring
- Compliance with DHCF's rules
- Payer cost savings and provider VBP performance

Data and analytics

Training and clinical protocols

YOUR PLAN COMMUNICATIONS TOOLKIT

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- Designated plan **liaison** within your organization
- A record or database of **important plan phone numbers and contacts**
- Plan **provider manual** (each plan will have one)

UTILIZATION MANAGEMENT (BEFORE) VS. UTILIZATION REVIEW (AFTER)

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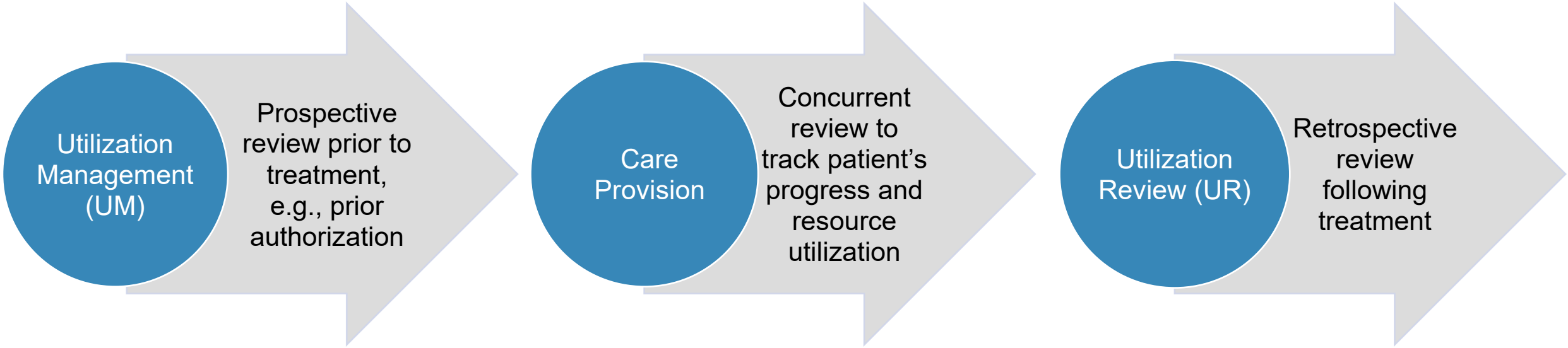
UM and UR are both used to determine whether health care resources are being used efficiently.



THE BIG THREE UTILIZATION MANAGEMENT GOALS

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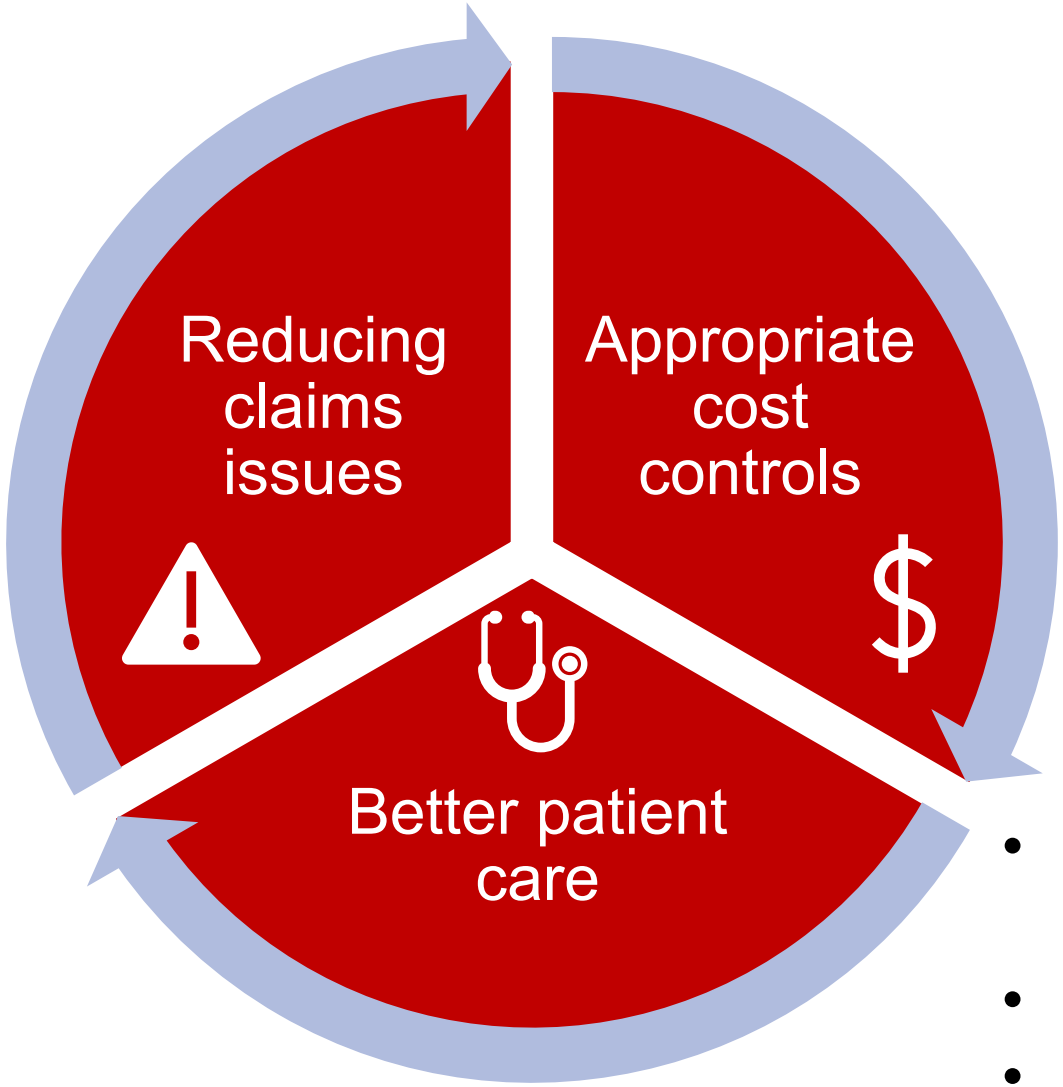
- **Reduction in issues at the claims level**



- **Right care**
- **Right place**
- **Right time**

- **Reduction in inappropriate under and over utilization**
- **Evidence-based**
- **Outcomes measured**

ELEMENTS OF UTILIZATION MANAGEMENT

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- Pre-certification/Prior Authorization
- Discharge Planning
- Concurrent Planning
- Appeal/Dispute Processes

AUTHORIZATION

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- The individual is eligible
- Service is part of the approved service plan
- Service is within the established service caps
- It is the most appropriate (most integrated/least intensive) level of care
- Authorization must be provided within timeliness standards
- Meets medical necessity criteria
- In line with best practice guidelines

LEVEL OF CARE (LOC) CRITERIA

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Six evaluation dimensions:

1. Functional status
2. Co-morbidity
3. Recovery environment (environmental stress and environmental support)
4. Treatment history
5. Degree of engagement
6. Risk of harm to self or others, including potential for victimization or accidental harm

ASAM LEVEL OF CARE (LOC) CRITERIA FOR SUD

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But how do you determine which level of care is right for your patient?

Look at functioning in each of the six dimensions:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery Environment

DC Integration Update

The *ASAM Criteria* is now the chosen clinical framework for SUD treatment

Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®; 2013.

ASAM LEVEL OF CARE (LOC) IN SUD TREATMENT

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Level 0.5	Early Intervention
Level 1	Outpatient Services
Level 2.1	Intensive Outpatient Services
Level 2.5	Partial Hospitalization Services
Level 3.1	Clinically Managed Low Intensity Residential Services
Level 3.3	Clinically Managed Population Specific High-Intensity Residential Services (Adults Only)
Level 3.5	Clinically Managed High-Intensity Residential Services (Adult Criteria)
Level 3.5	Clinically Managed Medium-Intensity Residential Services (Adolescent Criteria)
Level 3.7	Medically Monitored Intensive Inpatient Services (Adult Criteria)
Level 3.7	Medically Monitored High Intensity Inpatient Services (Adolescent Criteria)
Level 4	Medically Managed Intensive Inpatient Services

DC BEHAVIORAL HEALTH INTEGRATION UPDATES: STANDARDIZED TOOLS – DLA-20 AND CAFAS/PECFAS

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DC Integration Update

DLA-20 and CAFAS/ PECFAS selected as standardized tools

DLA-20: The Daily Living Activites-20 (DLA-20) is an adult functional assessment tool designed to assess what daily living areas are impacted by mental illness or disability. The tool identifies interventions for functional needs to inform individualized service plans.

CAFAS/PECFAS: The Child & Adolescent Functional Assessment Scale ("CAFAS") and the Pre-school & Early Childhood Functional Assessment Scale ("PECFAS") are rating scales for youth ages 6-20 that assess functional impairment attributed to behavioral, emotional, psychological, or substance use disorders.

DC BEHAVIORAL HEALTH INTEGRATION UPDATES: STANDARDIZED TOOLS – DLA-20 AND CAFAS/PECFAS

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DLA-20	CAFAS/PECFAS
Requirement: DBH-Certified providers are expected to complete the DLA-20:	**Requirement:** DBH-Certified children/youth providers to complete the CAFAS/PECFAS:
1. At admission during the assessment process	1. Within 30 days or by the 4th visit whichever comes first following intake.
2. Every ninety (90) days thereafter	2. Every ninety (90) days thereafter
3. When a change in Level of Care occurs	3. During significant events affecting functioning that would impact service intensity and necessitate a treatment plan update
4. At discharge	4. At discharge

Source: Government of the District of Columbia. (2023, February 13). *Level of Care Determinizations for Adults in MHRS*. Department of Behavioral Health. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/COVID-19%20Guidance%20to%20Operators%20of%20Community-based%20Residences_0.pdf

DC MCO FY2023 BEHAVIORAL HEALTH-RELATED METRICS

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- Follow-up After Hospitalization for Mental Illness (FUH)*
  - 7 day
  - 30 day
- Follow-up After ED Visit for Mental Illness (FUM)*
  - 7 day
  - 30 day
- Screening for Depression and Follow-Up Plan
- Concurrent Use of Opioids and Benzodiazepines
- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Pharmacotherapy for Opioid Use Disorder

*Performance Improvement Projects are required for MCOs/CASSIP/DSNP

MEDICAL NECESSITY

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- Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
  - In accordance with generally accepted standards of medical practice
  - Clinically appropriate in terms of type, frequency, extent, site, and duration
  - Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider

Source: American Medical Association

JUSTIFYING MEDICAL NECESSITY

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- Consistent with symptoms or diagnosis
- Consistent with generally accepted professional medical standards
- Not for the convenience of the patient, any provider
- Neither more nor less than the patient requires at that time
- Not related to monetary status or benefit
- Documented

GRIEVANCES AND APPEALS

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- The Health Benefits Plan Members Bill of Rights Act of 1998 guarantees DC health plan members a progressive appeal/grievance process

Informal internal review
- 24 hours for emergency care
- 14 days for non-emergency

Formal internal review
- 24 hours for emergency care
- 30 days for non-emergency

Formal external review
- Procedure established by the Director of the Department of Health

D.C. Law 12-274. Health Benefits Plan Members Bill of Rights Act of 1998. https://code.dccouncil.gov/us/dc/council/laws/12-274.

OFFICE OF THE HEALTH CARE OMBUDSMAN

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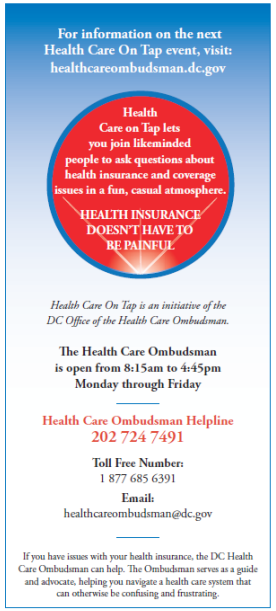
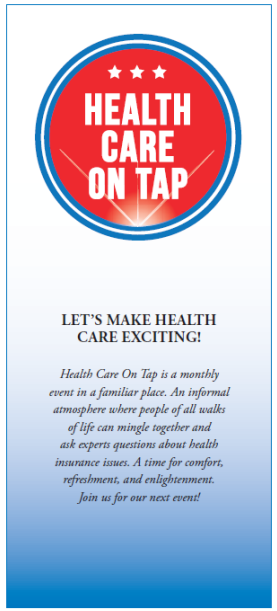
- Established by the Council of the District of Columbia, the Health Care Ombudsman Program assists individuals insured by health plans in the District and uninsured consumers in the District to:
  - Understand their health care rights and responsibilities;
  - Resolve problems with health care coverage, access to health care, or health care bills;
  - Appeal a health plan's decision; and
  - Find other health care resources.
- Website: https://healthcareombudsman.dc.gov





- Website: https://healthcareombudsman.dc.gov

CHANGE MANAGEMENT FOR BEHAVIORAL HEALTH LEADERSHIP

THE CASE FOR CHANGE

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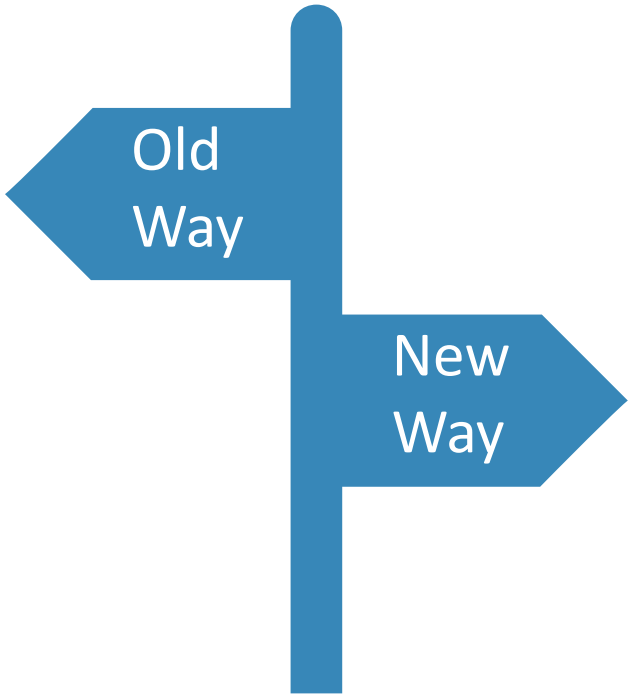

“It is not the strongest of species that survives, nor the most intelligent that survives.

It is the one that is the most adaptable to change.”

-Charles Darwin

THE SYSTEM HAS BEEN EVOLVING AND CHANGING SINCE IT WAS ESTABLISHED

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Dorothea Dix: 19th century
Moral Treatment

Adolph Meyer: Early 20th century
Biopsychosocial Treatment

Anti-psychotics: 1950s
Pharmacologic Treatment

Deinstitutionalization: 1960s
Community-Based Treatment

Recovery Movement: 1970s
Person-Centered Treatment

THE EVOLUTION HAS BEEN DIRECTIONALLY CONSISTENT

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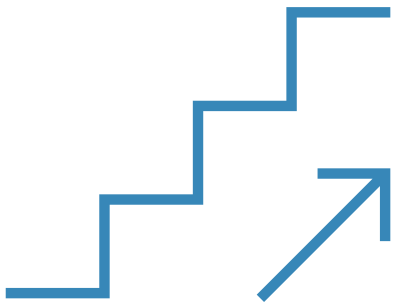

- Government investment and regulation
- Integration
  - Community
  - Other service systems
- Whole-person approach
  - Social Drivers of Health
- Level of complexity
- Respect for the humanity of people with mental illness
- Centrality of people with mental illness and their wants/needs

SUCCESS FACTORS FOR CHANGE MANAGEMENT

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1. Provide direct and visible leadership
2. Deploy teams to make changes
3. Test changes
4. Coach to support change
5. Make the way unavoidable
6. Allocate actual resources
7. Monitor what you want to sustain and spread
8. Create a culture of improvement

Source: Judge, K. H., Zahn, D., Lustbader, N. J., Thomas, S., Ramjohn, D., & Chin, M. (2007). Factors contributing to sustaining and spreading learning collaborative improvements: Qualitative research study findings by the Primary Care Development Corporation. *New York: Primary Care Development Corporation*.

QUESTIONS

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