2017 EQR Quality Forum Questions and Answers from the Speakers

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Medicaid Managed Care: Key Trends and Considerations

Greenville- October 3, 2017

1. Do some states separate IDD when moving toward managed Care?
   Yes, other states with Managed Care carve out the I/DD populations. It has often been the last population pulled into managed care.
2. Regarding the (up to) $25 co-pay that was implemented in Indiana for ED non-emergent visits, was other research done to see if resources in rural areas have an alternative care solution for these visits?
   We'll have to research whether Indiana evaluated alternatives for rural areas. Also, there is a 60-day grace period before lockout for failure to pay Power account contributions. This applies to able-bodied adults above 100% FPL.

Raleigh- October 6, 2017

3. A lockout period was discussed that other states have implemented. This is a period of non-coverage if the beneficiary has not made their contributions. Within this lockout, are there populations that are excluded? Yes, as implemented in Indiana, this applies to the new adult coverage group that is able-bodied adults over 100% FPL.
4. Louisiana did preserve behavioral health services as a carve out, but moved it to managed care. Is the construct an integration of behavioral health and physical health or is behavioral health managed separately, but under a managed care organization?
   Louisiana established Health Louisiana when they expanded Medicaid under the ACA and manage behavioral health services for adults and children as part of that program. They maintained their System of Care Waiver for children with significant behavioral health needs as a separate program.

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5. What is the Model for Managed Care NC? NC has evaluated managed care models in other states as it has worked to shape its managed care program. Tennessee and Massachusetts, among others, were evaluated as part of that effort to see what programs have been successful and to align options with the NC's goals and vision.
6. What is the time frame for roll out of the Model in NC or any state? Time to transition to managed care varies greatly by state and the model and/or program components they choose to implement. Most states take several years to design and implement their programs.

Amelia Muse, PhD, LMFTA, Director of Operations / Center of Excellence for Integrated Care

Integrating Primary Care and Behavioral Health Services

Greenville- October 3, 2017

7. Can you have 2 Integrated Care models implemented? Yes, Amelia provided a flow chart that shows how this will work. It's possible to flow between horizontal and vertical models. This is located on this link, under Review Services – EQR Training Resources. The file name is Crosswalk and Model Integration: https://thecarolinascenter.org/default.aspx?pn=TrainingMaterials
8. How will Integrated Care models help MCOs – Treating people in the primary care system with mild to moderate mental health conditions to free up the MCOs to work with people with more complex needs, IDD and SMPI.
9. What are the barriers with bidirectional integration? This is a model that places a primary care provider in the behavioral health setting. In this model, many times, the primary care is a light version (i.e., not managing chronic conditions but providing bridge medications or treating acute illness). Barriers include billing/reimbursement and site status/license to provide both services.
10. Is there an assessment for organizations to know how ready they are to progress toward integrated care? – Yes, the MeHaf is one of the industry wide readiness assessments used for assessing readiness for integrated care.

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11. What tools are you using to measure outcomes of implementation success of integrated care? The population reach has been the most useful outcome measure. This looks at how many people receive both behavioral health and primary care within their visits out of the whole patient population. Other outcomes can be looked at also include: screening results (depression and anxiety symptom changes over time), lab results (changes in hemoglobin A1c when behavioral intervention has been provided), and other clinical outcomes. These are outcomes that can be assessed by extracting data from the EHR.
12. How is integrated care billing handled? Some organizations are dependent on grant funding; they must continue to find grants to sustain their integrated service line, but the benefit is that they can often provide services to patients for free. Other organizations have their behavioral health providers credentialed with the LME/MCOs and/or private payors, and if they provide 16+ minutes of behavioral health services to patients (including intervention) during a warm handoff from a medical provider they can bill a psychotherapy code and be reimbursed for services.
13. How long does it take to move toward integrated care? – In my experience, one clinic generally takes one year to implement integrated behavioral health care and after two years the changes seem stable and sustainable.

14. What percent of submitted billing for integrated care is billed to the MCOs? Out of all the sites that my team works with, about 50-75% are submitting behavioral health services to the MCOs for reimbursement. About 15% of our sites are submitting for reimbursement to private payors. About 50% of all our sites have some type of grant funding that they rely on to either a) offset costs of the behavioral health integration that aren't covered by income from reimbursement, or b) totally fund the services provided to patients by the on-site behavioral health providers. (Disclaimer- this is all an estimate)

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15. Amelia asks, "What are the challenges of whole person care?" Group answers:
    a. IPS funding
    b. timeliness of data- with a 30-60 day lag in pharmacy and primary care data to behavioral health, care is segmented
    c. The care models are much different with behavioral health and physical health
16. Do social determinants of health impact the integrated care models or ease of implementing integrated care? Providing integrated behavioral health services aligns with addressing social determinants of health because adding a behavioral health service line in medical settings changes the scope of the practice from biomedical to biopsychosocial, and the social determinants of health are whole person oriented (biopsychosocial). Integrating services makes it easier to address social determinants of health.
17. Explain funding for integrated care? Funding relies on reimbursement since we are in a FFS system, or grant funding, which is not always sustainable. There is some evidence about cost savings to the system when integrated care is implemented, but the evidence on return on investment, for integrated behavioral health care specifically, is unclear. While integrated care might not turn a lot of profit for a health system, the benefit is really in the improved outcomes for quality measures required for NCQA, etc. There are significant challenges in sustaining integrated care in a FFS model, because sometimes 16+ minutes of BH intervention is not needed, but this is how the billing code and reimbursement is defined. This will be interesting to study when we move into value based reimbursement.

Nate Burgess, Regional Director / HMS

Encounter Data Validation

Greenville- October 3, 2017

18. Do you see different denials on the Medical side verses the Behavioral Health side? The types of denials on the medical side are very similar to what the Plans are encountering when submitting encounter data. The difference is the billing rules and policy specific edits that are being applied to Medical vs Behavioral Health.
19. If Policy contradicts a CCI edit, what's the correct action to take? Any contradictions should be presented to CMS to grant an exception. The only time this should be done is if the CCI edit is

limiting access to care. Any concerns with CCI edits should be coordinated with DMA Contract Manager. The state has a process and point person for working with CMS on any CCI exceptions.

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None

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Questions were all directed at DMA after Nate's presentation.

Questions for DMA from Morganton Forum:

DMA has responded to the following questions through The Council of Community Programs. DMA has offered technical assistance to all MCOs. For those MCOs that are not part of The Council of Community Programs, technical assistance was provided by the NC Division of Information Technology through Cheryl McQueen. If additional technical assistance is needed, please contact Adolph Simmons.

20. How are encounters edited/ adjudicated at DMA? How and what edits are applied?
21. If there is a secondary Diagnosis when submitting a claim (on the 837) that is not related to behavioral services, the payment is denied. Assuming that DMA will want all diagnoses codes submitted by a provider, what plans are there to modify edits in order to accept all diagnosis codes reported?
22. DMA and DMH have different encounter edits and taxonomy edits. DMH does not edit on taxonomy. Is there a way to synchronize them or make them more like each other?
23. It is difficult to replicate edits that are being applied on NCTracks vs by each plan based on the edit information provided to date. A report of edit codes and their description has been provided; however, we must "reverse engineer" the edit based on denials and an edit name. It would benefit each plan to perform a deeper dive with CSRA and DMA in order to understand the code or logic behind each edit.
24. It would helpful to be able to interact with CSRA directly to discuss issues and not MCO to DMA.
25. Will credentialing be completed solely by DMA? Cardinal waiting follow-up since EQR 2016 Quality Forum.
26. There is a fundamental problem with NC Tracks. It was not designed to be a managed care system and now we must implement work-arounds that are not ideal for the state or the MCO. It is a very risky and manual process.
27. It is difficult to reconcile denials when they are denied due to the current reporting format. The ideal solution would be to move to a standard 835 response so each plan can tie back all payments and denials to each claim/line submitted.