Ohio
Department of Medicaid

Ohio
MENTAL HEALTH & ADDICTION SERVICES

BH Redesign Core Team
Managed Care Focus

May 27, 2015

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Ohio Mental Health & Addiction Services

Agenda

- **Welcome, Introductions, Review Agenda & Process for Decision-Making**, Greg Moody
- **Review of Behavioral Health Priorities & Timeline**, Tracy Plouck
- **Review of design decisions to-date**, John McCarthy
  - Model 2
  - Full Population
  - All Services
- **Overview of Population-Based Care Management Model,** Kara Miller
- **Key Design Dimensions**, Angie Bergefurd, Christi Pepe, Kara Miller
  - Open Decisions
  - Framework for Decision Making
  - Standardize
    - Care Coordination Delegation Requirements & Examples
    - Other?
  - Align in Principle
  - Differ by Design
- **Process for gaining feedback on open decisions**, Greg Moody
- **Payment Innovation**, Karin Hoyt
  - What is episode-based payment?
  - How does it improve care?
- Next Steps

Ohio's priorities for Behavioral Health (BH) redesign

1915i Program for Adults with SPMI

- **Ensure continued access to care for ~4-6K adults with SPMI** who meet financial and clinical / needs criteria and who are at risk of potential loss of eligibility for Medicaid
- **Cover new services** such as Recovery Management and Behavioral and Primary Healthcare Coordination, IPS Supported Employment, Peer Recovery Support

Rebuilding Community BH System Capacity

- **Recode Medicaid BH services to achieve alignment with national coding standards** (AMA, HCPCS, Medicare, NCCI/MUE)
- **Disaggregate certain existing services** (Community Psychiatric Supportive Treatment, Case Management and Health Home services) and **provide for lower acuity service coordination** and support services
- **Develop new services for people with high intensity needs under the Medicaid Rehabilitation Option:** Assertive Community Treatment, Intensive Home Based Treatment, residential treatment for substance abuse
- Achieve cost neutrality in making these changes

Managed BH Care

- **Addition of BH services to Managed Care Plan contract**, with specific requirements for MCPs to delegate components of care coordination to qualified Community Behavioral Health providers

Payment innovation

- **Design and implement new health care delivery payment systems to reward the value of services, not volume**
- Develop approach for introducing episode based payment for BH services

1 300% of SSI, includes $20 personal needs disregard ($2,219 in CY 2015); Clinical includes diagnostic (diagnostic (schizophrenia, bipolar or major depressive affective disorders-severe) and score on Adult Needs and Strengths Assessment) tool

2 Assertive Community Treatment, Intensive Home Based Treatment, residential treatment for substance abuse

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Timeline for BH redesign

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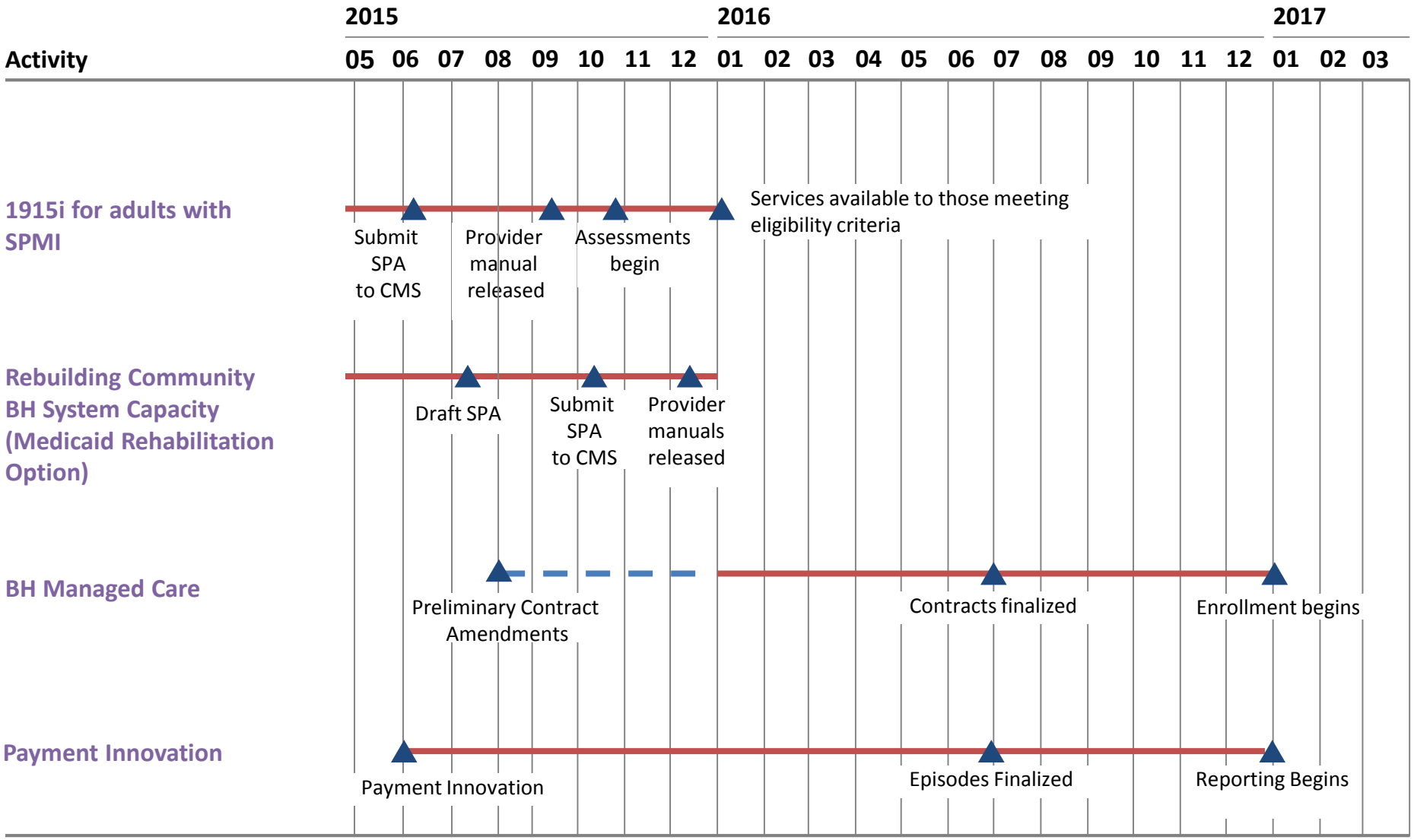


Proposed Care Coordination Model

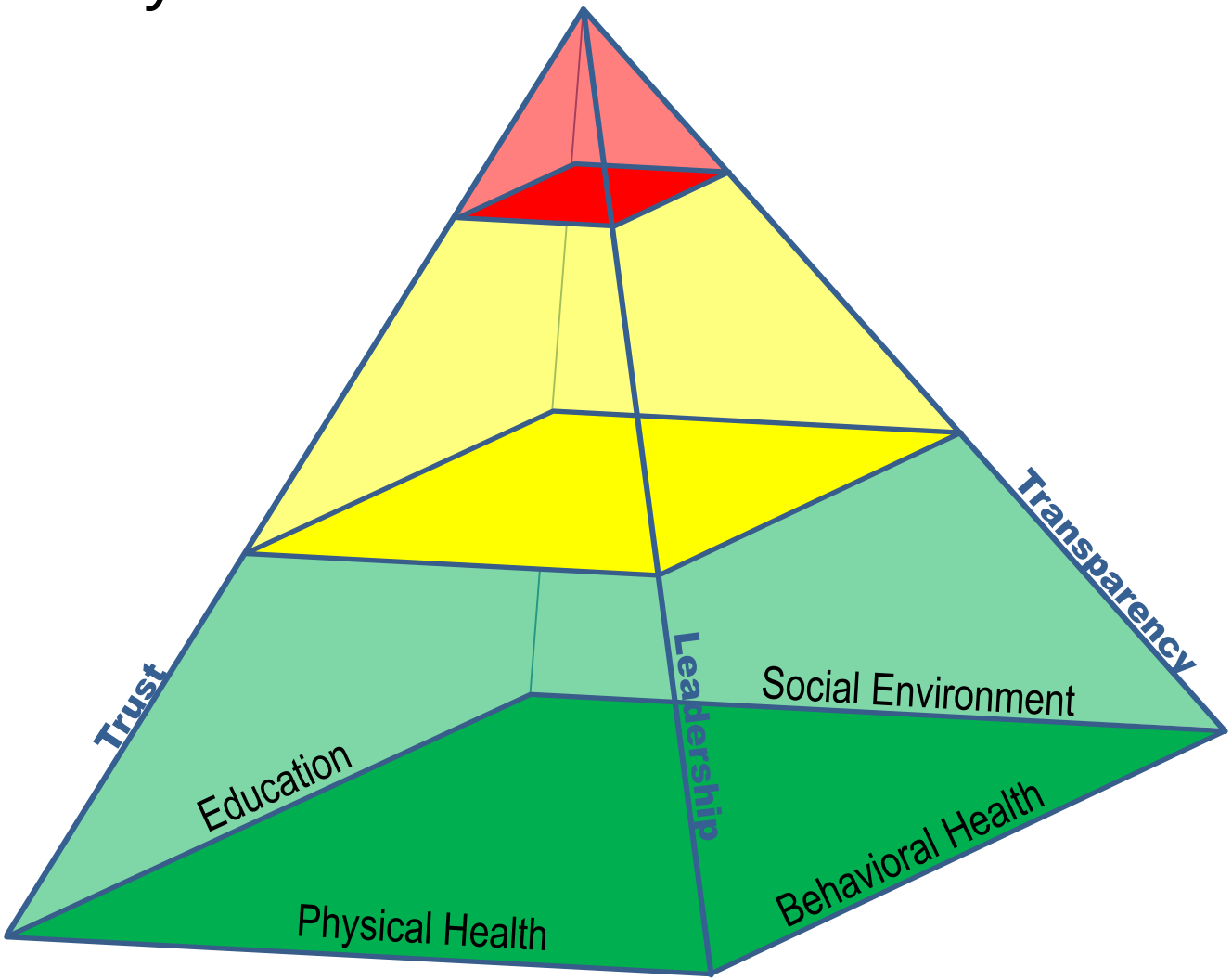
- Carve in Ohio's Medicaid behavioral health services to Ohio's current Medicaid managed care plan contract
- Require MCPs to delegate components of care coordination to qualified community behavioral health providers

Standardized Approach	Align in Principle	Differ by Design
• Clinical outcomes and plan performance measures • Care management identification strategy for high risk population • Billing and coding methodologies • Benefit design	• Real time data sharing and use of HER, where possible • Require value based purchasing/contracting • Utilization management strategies (e.g. prior authorizations, forms, process, etc.)	• Purchase services to enhance expertise in behavioral health service coordination/delivery • Payment strategies • Selective contracting

Population Health Management

- Health outcomes of a group of individuals, and the distribution of health outcomes within the group

Pyramid of Health



HIGHEST:
Individual effort, Complexity, Cost

LOWEST:
Impact

Population Health in Medicaid

1) Priority populations:
   - Maternal and child health
   - Behavioral health (children and adults)
   - Chronic conditions (children and adults)
   - Healthy adults – acute and self limited conditions

2) Health equity – addressing social determinants of health

3) Healthy behaviors

4) Outcomes – Inpatient utilization, ED utilization, Cost/ROI, Potentially Preventable Events, Clinical performance measures, infant mortality, patient safety, consumer satisfaction

Medicaid Managed Care Delivery Model

Model of care design features*:

- Health and wellness
- Preventive care
- Primary care
- Access to specialists
- Transitions of care
- Care management

*Included in the MCP Provider Agreement

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Transforming the MCP Care Management Strategy

- Move to a population health management approach and expand the Managed Care Plans' care management efforts beyond the "1%"
- Synchronize MCP care management efforts with ODM/OHT efforts (SIM, PCMH).
- Align the care management responsibility with the entity best poised to connect with the beneficiary and influence behavior change.
- Better support existing community-based care management models.

Care Management Re-Design

- Introduce to the MCP Provider Agreement – July 1, 2015
- Builds on existing foundation that aligns with national standards for case management
- Framework that positions managed care program for management of additional populations/services

MCP Care Management

What makes a high performance care management system?

- Patient and family centeredness
- Proactive, planned and comprehensive
- Promotes self-care and independence
- Emphasizes cross-continuum and system collaboration and relationships
- Address physical, behavioral and social determinants of health

Care Management Program Requirements

- Aggregation of data across multiple IT resources and identification mechanisms
- Risk stratification infrastructure
  - Stratify and assess risk factors
  - Include five risk levels: intensive, high, medium, low and monitoring
- Assessments
  - All consumers will have a health risk assessment
  - Comprehensive assessments required for consumers in the intensive and high levels
  - Relevant, recent, multiple data sources – interviews with consumer/family/providers, claims, prior authorizations, existing assessments

Care Management Program Requirements

- Care Plans
  - Individualized care plans based on assessed needs for consumers in top two tiers
  - Baseline health and wellness plan with specific goals – clinical, based on HEDIS measures – for lower risk levels
  - Input by consumer and provider
  - Developed, implemented, monitored and updated

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Care Management Program Requirements

- Care manager & care management team:
  - Each consumer assigned an accountable care manager
  - Use of a multi-disciplinary team (PCP, specialists, consumer, CBHCs, etc) to provide services and coordinate care appropriate for consumer's needs
  - Meet staffing ratio requirements defined as one full time equivalent (FTE) per number of consumers specified for top two tiers:
    - Intensive: 1:25 – 1:50
    - High: 1:51 – 1:100
  - Expand team concept to accommodate range of relationships that can exist between MCP and community based care coordination (PCPs, CBHCs)
  - Ensure that staff performing CM functions are appropriately qualified – scope of practice, licensing considerations

Care Management Program Requirements

- Contact Schedule
  - Based on consumer needs
  - Minimum contact prescribed for top two tiers:
    - Intensive: 1 in person contact per quarter; 1 in home visit within the first six months and annually thereafter
    - High: 1 in person contact every 6 months; 1 in home visit per year
  - Allows for use of video communication
  - Any member of the CM team can conduct in person contact – tied to goals in care plan

Care Management Program Requirements

- Coverage requirements
  - All consumers will receive care management.
  - Extend care management services as follows:
    - Intensive: 1% of the MCP's overall membership
    - High: 2% of the MCP's overall membership
    - Medium, low, and monitoring: 97% of the MCP's membership across stratification levels
  - Expected level of participation in care management

Care Management Program Requirements

- Accountability for care management
  - Staffing ratio
  - Patient Activation Measure survey
  - Retention and graduation rates
  - Audits conducted by external quality review organization – assessments, care plans, coordination of services, case reviews for home-bound consumers

Defining relationships between MCPs and Providers

- Review of the options
  - Full or partial delegation
  - Collaboration
  - Encounter based

Defining relationships between MCPs and Providers

- Defining delegation
  - Formal process by which the MCP gives another entity (vendor, provider) the authority to perform a function (or program requirement) on its behalf
  - MCP is ultimately held responsible
    - An MCP may give delegate authority to act on its behalf but the MCP is ultimately accountable.
  - Applies to full and/or partially delegated arrangements.

Defining relationships between MCPs and Providers

- MCP delegation requirements (OAC)
  - Fully executive written agreement specifying responsibilities
  - Pre-delegation assessment to ensure entity is capable of performing delegated function
  - Require the delegated entity to submit a monthly report summarizing status of activity, including identified issues/concerns
  - Monitor performance on an ongoing basis and submit an annual assessment of data
  - Include in the written agreement the sanctions that will be imposed for performance issues.
- NCQA delegation requirements

Defining relationships between MCPs and Providers

- Encounter based
  - CPT codes
  - PMPM for care coordination/management
- Collaboration

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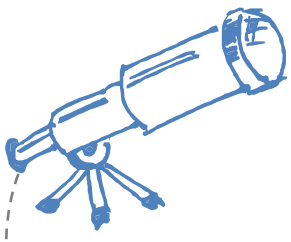
Key Design Dimensions for Consideration

Key Design Dimension	Description
Network Adequacy	• Assuring access to needed services and supports
Integration	• Integrating physical health, behavioral health and other needed services and supports
Accountability	• Clearly defining MCP & provider roles & responsibilities
Timeline	• Developing a transition plan
Stakeholder Involvement	• Involving Consumers, MCPs, Providers, Boards & Others in design process
Experience	• Assuring adequate MCP experience and expertise with individuals with SPMI, SMI & SUD
Care Management	• Defining care management functionality & accountability at appropriate levels
Standardization Across MCPs	• Prior Authorization, Billing, Claims Processing & Payment Requirements
Data and Outcomes	• Assuring capacity & developing infrastructure and focusing on **outcomes** not process

Process for Follow Up Between Large Group Meetings



The process below will be used for follow up between large group meetings develop key decisions on the details of design dimensions.

Identify Key Decisions to be Made in Large Group Meeting

Conduct Ad Hoc Consultations with Stakeholders

Communicate Draft Decisions to Stakeholders

Finalize Decisions in Large Group

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Governor's Office of Health Transformation

Five year goal for payment innovation

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Goal	80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years
State's Role	▪ Shift rapidly to PCMH and episode model in Medicaid fee-for-service ▪ Require Medicaid MCO partners to participate and implement ▪ Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi)	▪ State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
Year 2	▪ Collaborate with payers on design decisions and prepare a roll-out strategy	▪ State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

How episode-based payment works

Patients and providers continue to deliver care as they do today

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

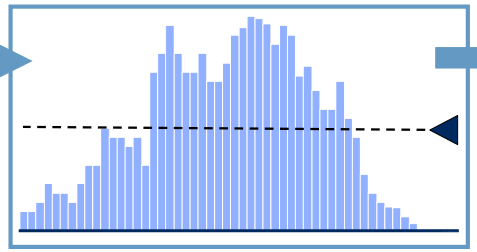
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5 Payers calculate **average cost per episode** for each PAP



Compare average costs to predetermined "commendable" and "acceptable" levels

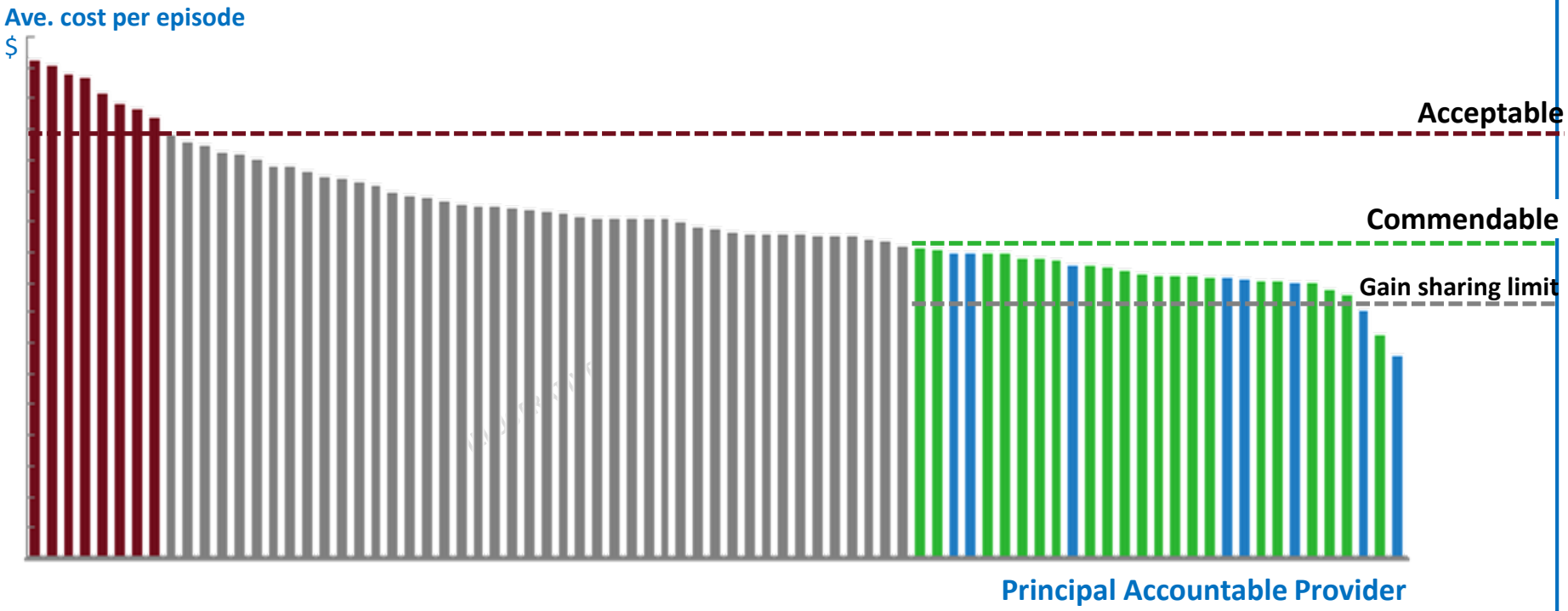
6 **Providers may:**

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay part of excess cost:** if average costs are above acceptable level
- **See no change in pay:** if average costs are between commendable and acceptable levels

Episode-based payment rewards cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- ***Risk sharing*** Pay portion of excess costs
- ***No change*** Payment unchanged
- ***No Change*** Eligible for gain sharing based on cost, but did not pass quality metrics
- ***Gain sharing*** Eligible for incentive payment



NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

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Ohio has launched 6 medical episodes and is currently developing an additional 7, with more waves of development planned for 2016-2017

Launched episodes	Episodes currently in development
▪ Asthma exacerbation	▪ URI
▪ COPD exacerbation	▪ UTI
▪ Perinatal	▪ Cholecystectomy
▪ Total joint replacement	▪ Appendectomy
▪ Acute PCI	▪ Upper GI Endoscopy
▪ Non-acute PCI	▪ Colonoscopy
	▪ GI Bleed

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Potential sources of value to address in behavioral health

Optimize timing, frequency and duration of treatment supported by best practice	▪ Intervene early and evaluate patients on an ongoing basis ▪ Provide levels of treatment consistent with best practice
Optimize medication use	▪ Avoid over-prescription as well as under-prescription – both have been identified as problems
Shift care to appropriate care setting and type	▪ Select inpatient vs. outpatient setting, therapy vs. pharmacological treatment to fit the diagnostic profile
Coordinate care across care settings	▪ Create treatment plans and share information between providers to ensure seamless care and avoid unnecessary exacerbations

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- Next Steps
  - BH Core Team Meeting
    - June 11, 2015, 1:00-3:00
    - 1915(i), MRO & Managed Care
  - Episode Based Payment Meeting
    - June 11, 2015

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Questions?